

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

In the Matter of the Accusation Against:

**PETER CRAIG CALDWELL, doing
Business as L M CALDWELL
PHARMACIST
PETER CRAIG CALDWELL, OWNER
Pharmacy Permit No. PHY 30911**

**PETER CRAIG CALDWELL, doing
Business as L M CALDWELL
PHARMACIST
PETER CRAIG CALDWELL, OWNER
Pharmacy Permit No. PHY 30912**

**PETER CRAIG CALDWELL
RPH 25356**

**ABDUL YAHYAVI
RPH 30041**

Respondents.

Case No. 4867

OAH No. 2015100819

**AS TO PETER CRAIG
CALDWELL INDIVIDUALLY
ONLY**

DECISION AND ORDER

The attached Stipulated Surrender of License and 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 November 23, 2016.

It is so ORDERED on October 24, 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
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7 *Attorneys for Complainant*

8 **BEFORE THE**
BOARD OF PHARMACY
9 **DEPARTMENT OF CONSUMER AFFAIRS**
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 4867

12 **PETER CRAIG CALDWELL doing**
13 **business as L M CALDWELL**
PHARMACIST
14 **PETER CRAIG CALDWELL, OWNER**
15 **1509 State St.**
Santa Barbara, CA 93101
Pharmacy Permit No. PHY 30911

OAH No. 2015100819

STIPULATED SURRENDER OF
LICENSE AND ORDER

AS TO PETER CRAIG CALDWELL,
INDIVIDUALLY ONLY

17 **PETER CRAIG CALDWELL doing**
18 **business as L M CALDWELL**
PHARMACIST
19 **PETER CRAIG CALDWELL, OWNER**
20 **235 West Pueblo St.**
Santa Barbara, CA 93105
Pharmacy Permit No. PHY 30912

21 **PETER CRAIG CALDWELL**
22 **1509 State St.**
Santa Barbara, CA 93101
23 **Pharmacist License No. RPH 25356**

24 **ABDUL YAHYAVI**
25 **1624 La Coronilla Drive.**
Santa Barbara, CA 93109
26 **Pharmacist License No. RPH 30041**

27 Respondents.

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

3 PARTIES

4 1. Virginia Herold (Complainant) is the Executive Officer of the Board of Pharmacy.
5 She brought this action solely in her official capacity and is represented in this matter by Kamala
6 D. Harris, Attorney General of the State of California, by Cristina Felix, Deputy Attorney
7 General.

8 2. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit
9 Number PHY 30911 to Peter Craig Caldwell to do business as L M Caldwell Pharmacist located
10 at 1509 State Street, Santa Barbara, CA 93101. Peter C. Caldwell has been the individual
11 licensed owner since December 13, 1984. The Pharmacy Permit will expire on December 1,
12 2016, unless renewed. Peter C. Caldwell has been the individual licensed owner of L M Caldwell
13 Pharmacist since December 13, 1984. Peter Craig Caldwell has been the Pharmacist-In-Charge
14 of L M Caldwell Pharmacist since December 1, 1984.

15 3. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit
16 Number PHY 30912 to Peter Craig Caldwell to do business as L M Caldwell Pharmacist located
17 at 235 West Pueblo Street, Santa Barbara, CA 93105. Peter Craig Caldwell has been the
18 individual licensed owner since December 13, 1984. The Pharmacy Permit will expire on
19 December 1, 2016, unless renewed.

20 4. On or about January 9, 1968, the Board of Pharmacy issued Pharmacist License
21 Number RPH 25356 to Peter Craig Caldwell (Respondent Caldwell). The Pharmacist License
22 was in full force and effect at all times relevant to the charges in the Second Amended Accusation
23 No. 4867 and will expire on May 31, 2017, unless renewed.

24 5. Peter Craig Caldwell is represented in this proceeding by attorney William C.
25 Haggerty, Esq. Ford, Walker, Haggerty & Behar, whose address is One World Trade Center, 27th
26 Floor, Long Beach, CA 90831.

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JURISDICTION

6. Second Amended Accusation No. 4867 was filed before the Board of Pharmacy (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Second Amended Accusation and all other statutorily required documents were properly served on Respondent on June 30, 2016. Respondent timely filed his Notice of Defense contesting the Second Amended Accusation. A copy of Second Amended Accusation No. 4867 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

7. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Second Amended Accusation No. 4867. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

8. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Second Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

9. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

10. Respondent understands that the charges and allegations in Second Amended Accusation No. 4867, if proven at a hearing, constitute cause for imposing discipline upon his Pharmacist License.

11. For the purpose of resolving the Second Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Second Amended Accusation and that those charges

1 constitute cause for discipline. Respondent hereby gives up his right to contest that cause for
2 discipline exists based on those charges.

3 12. Respondent understands that by signing this stipulation he enables the Board to issue
4 an order accepting the surrender of his Pharmacist License without further process.

5 RESERVATION

6 13. The admissions made by Respondent herein are only for the purposes of this
7 proceeding, or any other proceedings in which the Board or other professional licensing agency is
8 involved, and shall not be admissible in any other criminal or civil proceeding.

9 CONTINGENCY

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

19 15. The parties understand and agree that Portable Document Format (PDF) and facsimile
20 copies of this Stipulated Surrender of License and Order, including Portable Document Format
21 (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

22 16. This Stipulated Surrender of License and Order is intended by the parties to be an
23 integrated writing representing the complete, final, and exclusive embodiment of their agreement.
24 It supersedes any and all prior or contemporaneous agreements, understandings, discussions,
25 negotiations, and commitments (written or oral). This Stipulated Surrender of License and Order
26 may not be altered, amended, modified, supplemented, or otherwise changed except by a writing
27 executed by an authorized representative of each of the parties.

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1 17. In consideration of the foregoing admissions and stipulations, the parties agree that
2 the Board may, without further notice or formal proceeding, issue and enter the following Order:

3 **ORDER**

4 IT IS HEREBY ORDERED that Pharmacist License No. RPH 25356 issued to Respondent
5 Peter Craig Caldwell, is surrendered and accepted by the Board of Pharmacy.

6 1. The surrender of Respondent's pharmacist license and the acceptance of the
7 surrendered license by the Board shall constitute the imposition of discipline against Respondent.
8 This stipulation constitutes a record of the discipline and shall become a part of Respondent's
9 license history with the Board of Pharmacy.

10 2. Respondent shall lose all rights and privileges as a Pharmacist in California as of the
11 effective date of the Board's Decision and Order.

12 3. The surrender of Respondents' pharmacist license is stayed until thirty (30) day from
13 the effective date of the Board's Decision and Order. Respondent shall lose all rights and
14 privileges as a pharmacist thirty days after the effective date of the Board's Decision and Order.
15 On the effective date of the Board's Decision and Order, Respondent cannot act as a Pharmacist
16 In Charge.

17 4. Respondent shall cause to be delivered to the Board his pocket license and, if one was
18 issued, his wall certificate, thirty days after the effective date of the Board's Decision and Order.

19 5. If he ever applies for licensure or petitions for reinstatement in the State of California,
20 the Board shall treat it as a new application for licensure. Respondent must comply with all the
21 laws, regulations and procedures for licensure in effect at the time the application or petition is
22 filed, and all of the charges and allegations contained in Second Amended Accusation No. 4867
23 shall be deemed to be true, correct and admitted by Respondent when the Board determines
24 whether to grant or deny the application or petition. Respondent shall satisfy all requirements
25 applicable to that license as of the date the application is submitted to the board, including, but
26 not limited to taking and passing the California Pharmacist Licensure Examination prior to the
27 issuance of a new license. Respondent is required to report this surrender as disciplinary action.
28

1 6. If Respondent should ever apply or reapply for a new license or certification, or
 2 petition for reinstatement of a license, by any other health care licensing agency in the State of
 3 California, all of the charges and allegations contained in Second Amended Accusation, No. 4867
 4 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement
 5 of Issues or any other proceeding seeking to deny or restrict licensure.

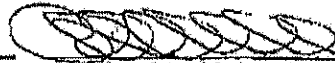
6 7. Respondent may not apply, reapply, or petition for any licensure or registration of the
 7 Board for three (3) years from the effective date of the Decision and Order.

ACCEPTANCE

8
 9 I have carefully read the above Stipulated Surrender of License and Order and have fully
 10 discussed it with my attorney, William C. Haggerty, Esq. I understand the stipulation and the
 11 effect it will have on my Pharmacist License. I enter into this Stipulated Surrender of License
 12 and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and
 13 Order of the Board of Pharmacy.

14
 15 DATED:

8/17/2016

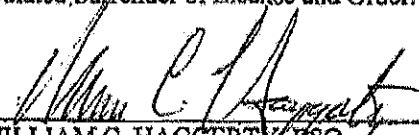


PETER CRAIG CALDWELL
Respondent

17 I have read and fully discussed with Respondent Peter Craig Caldwell the terms and
 18 conditions and other matters contained in this Stipulated Surrender of License and Order. I
 19 approve its form and content.

20 DATED:

8/18/16



WILLIAM C. HAGGERTY, ESQ.
FORD, WALKER, HAGGERTY & BEHAR
Attorneys for Respondent

ENDORSEMENT

24 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted
 25 for consideration by the Board of Pharmacy of the Department of Consumer Affairs.
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Dated: 08/18/2016

Respectfully submitted,
KAMALA D. HARRIS
Attorney General of California
THOMAS L. RINALDI
Supervising Deputy Attorney General



CRISTINA FELIX
Deputy Attorney General
Attorneys for Complainant

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2 THOMAS L. RINALDI
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7 *Attorneys for Complainant*

8 **BEFORE THE**
9 **BOARD OF PHARMACY**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 4867

13 **PETER CRAIG CALDWELL doing**
14 **business as L M CALDWELL**
15 **PHARMACIST**

SECOND AMENDED ACCUSATION

16 **PETER CRAIG, OWNER**
17 **1509 State St.**
18 **Santa Barbara, CA 93101**
19 **Pharmacy Permit No. PHY 30911**

20 **L M CALDWELL PHARMACIST**
21 **doing business as L M CALDWELL**
22 **PHARMACIST**
23 **PETER CRAIG, OWNER**
24 **235 West Pueblo St.**
25 **Santa Barbara, CA 93105**
26 **Pharmacy Permit No. PHY 30912**

27 **PETER CRAIG CALDWELL**
28 **1509 State St.**
Santa Barbara, CA 93101
Pharmacist License No. RPH 25356

ABDUL YAHYAVI
1624 La Coronilla Drive.
Santa Barbara, CA 93109
Pharmacist License No. RPH 30041

Respondents.

1 Complainant alleges:

2 PARTIES

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

6 2. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit
7 Number PHY 30911 to Peter Caldwell to do business as L M Caldwell Pharmacist located at
8 1509 State Street, Santa Barbara, CA 93101 (Respondent L M Caldwell Pharmacist-State Street).
9 Peter C. Caldwell has been the individual licensed owner since December 13, 1984. The
10 Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein
11 and will expire on December 1, 2016, unless renewed. Peter C. Caldwell has been the individual
12 licensed owner of Respondent State Street Pharmacy since December 13, 1984. Peter C.
13 Caldwell has been the Pharmacist-In-Charge of Respondent State Street Pharmacy since
14 December 1, 1984.

15 3. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit
16 Number PHY 30912 to LM Caldwell to do business as L M Caldwell Pharmacist located at 235
17 West Pueblo Street, Santa Barbara, CA 93105 (Respondent L M Caldwell Pharmacist- Pueblo
18 Street). Peter C. Caldwell has been the individual licensed owner since December 13, 1984. The
19 Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein
20 and will expire on December 1, 2016, unless renewed. Abdul Yahyavi was the Pharmacist-In-
21 Charge of Respondent Pueblo Street Pharmacy from December 1, 1984 to October 8, 2014.
22 Catherine Young Nance was the Pharmacist in Charge from October 1, 2014 to December 24,
23 2014. Eleonora Volf became the Pharmacist in Charge on December 24, 2014.

24 4. On or about January 9, 1968, the Board of Pharmacy issued Pharmacist Number
25 25356 to Peter Craig Caldwell (Respondent Caldwell). The Pharmacist License was in full force
26 and effect at all times relevant to the charges brought herein and will expire on May 31, 2017,
27 unless renewed.

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1 5. On or about December 10, 1975, the Board of Pharmacy issued Pharmacist Number
2 30041 to Abdul Yahyavi (Respondent Yahyavi). The Pharmacist License was in full force and
3 effect at all times relevant to the charges brought herein and will expire on June 30, 2016, unless
4 renewed.

5 **JURISDICTION**

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

9 7. Section 118, subdivision (b), of the Code provides that the suspension/expiration/
10 surrender/cancellation of a license shall not deprive the Board/Registrar/Director of jurisdiction to
11 proceed with a disciplinary action during the period within which the license may be renewed,
12 restored, reissued or reinstated.

13 8. Section 4300 of the Code states:

14 (a) Every license issued may be suspended or revoked.

15 (b) The board shall discipline the holder of any license issued by the board, whose
16 default has been entered or whose case has been heard by the board and found guilty,
by any of the following methods:

17 (1) Suspending judgment.

18 (2) Placing him or her upon probation.

19 (3) Suspending his or her right to practice for a period not exceeding on
20 year.

21 (4) Revoking his or her license.

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

24 ...

25 (e) The proceedings under this article shall be conducted in accordance with Chapter
26 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code,
and the board shall have all the powers granted therein. The action shall be final,
27 except that the propriety of the action is subject to review by the superior court
28 pursuant to Section 1094.5 of the Code of Civil Procedure.

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9. Section 4300.1 of the Code states:

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

10. Section 4307 of the Code states:

(a) Any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under suspension, or who has been a manager, administrator, owner, member, officer, director, associate, or partner of any partnership, corporation, firm, or association whose application for a license has been denied or revoked, is under suspension or has been placed on probation, and while acting as the manager, administrator, owner, member, officer, director, associate, or partner had knowledge of or knowingly participated in any conduct for which the license was denied, revoked, suspended, or placed on probation, shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee as follows:

(1) Where a probationary license is issued or where an existing license is placed on probation, this prohibition shall remain in effect for a period not to exceed five years.

(2) Where the license is denied or revoked, the prohibition shall continue until the license is issued or reinstated.

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

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

STATUTORY AUTHORITY

11. Section 4301 of the Code states:

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

(a) Gross immorality.

1 (b) Incompetence.

2 (c) Gross negligence.

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

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

12 ...

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

15 ...

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

21 ...

22 12. Section 4022 of the Code states

23 "Dangerous drug" or "dangerous device" means any drug or device unsafe for
24 self-use in humans or animals, and includes the following:

25 (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without
26 prescription," "Rx only," or words of similar import.

27 (b) Any device that bears the statement: "Caution: federal law restricts this device to
28 sale by or on the order of a _____," "Rx only," or words of similar import, the
blank to be filled in with the designation of the practitioner licensed to use or order
use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed
only on prescription or furnished pursuant to Section 4006.

13. Section 4059 of the Code states:

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

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

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

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

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

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

15 14. Section 4081 of the Code states:

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

27 (b) The owner, officer, and partner of any pharmacy, wholesaler, or veterinary
28 food-animal drug retailer shall be jointly responsible, with the pharmacist-in-charge
or representative-in-charge, for maintaining the records and inventory described in
this section.

(c) The pharmacist-in-charge or representative-in-charge shall not be criminally
responsible for acts of the owner, officer, partner, or employee that violate this
section and of which the pharmacist-in-charge or representative-in-charge had no
knowledge, or in which he or she did not knowingly participate.

15. Section 4105 of the Code states:

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

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

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

(d) Any records that are maintained electronically shall be maintained so that the

1 pharmacist-in-charge, the pharmacist on duty if the pharmacist-in-charge is not on
2 duty, or, in the case of a veterinary food-animal drug retailer or wholesaler, the
3 designated representative on duty, shall, at all times during which the licensed
4 premises are open for business, be able to produce a hard copy and electronic copy of
5 all records of acquisition or disposition or other drug or dispensing-related records
6 maintained electronically.

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

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

12 (f) When requested by an authorized officer of the law or by an authorized
13 representative of the board, the owner, corporate officer, or manager of an entity
14 licensed by the board shall provide the board with the requested records within three
15 business days of the time the request was made. The entity may request in writing an
16 extension of this timeframe for a period not to exceed 14 calendar days from the date
17 the records were requested. A request for an extension of time is subject to the
18 approval of the board. An extension shall be deemed approved if the board fails to
19 deny the extension request within two business days of the time the extension request
20 was made directly to the board.

21 16. Section 4333 of the Code states, in pertinent part, that all prescriptions filled by a
22 pharmacy and all other records required by Section 4081 shall be maintained on the premises and
23 available for inspection by authorized officers of the law for a period of at least three years. In
24 cases where the pharmacy discontinues business, these records shall be maintained in a
25 board-licensed facility for at least three years.

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

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

(b) Any person who knowingly violates this section shall be punished by
imprisonment in the state prison or in the county jail not exceeding one year, or by a
fine not exceeding twenty thousand dollars (\$20,000), or by both a fine and
imprisonment.

(c) No provision of the amendments to this section enacted during the second year of
the 1981-82 Regular Session shall be construed as expanding the scope of practice of

a pharmacist.

18. Health and Safety Code section 11200 states in pertinent part:

(a) No person shall dispense or refill a controlled substance prescription more than six months after the date thereof.

(b) No prescription for a Schedule III or IV substance may be refilled more than five times and in an amount, for all refills of that prescription taken together, exceeding a 120-day supply.

(c) No prescription for a Schedule II substance may be refilled.

STATE REGULATORY AUTHORITY

19. California Code of Regulations, title 16, section 1711, states:

(a) Each pharmacy shall establish or participate in an established quality assurance program which documents and assesses medication errors to determine cause and an appropriate response as part of a mission to improve the quality of pharmacy service and prevent errors.

...

(d) Each pharmacy shall use the findings of its quality assurance program to develop pharmacy systems and workflow processes designed to prevent medication errors. An investigation of each medication error shall commence as soon as is reasonably possible, but no later than 2 business days from the date the medication error is discovered. All medication errors discovered shall be subject to a quality assurance review.

(e) The primary purpose of the quality assurance review shall be to advance error prevention by analyzing, individually and collectively, investigative and other pertinent data collected in response to a medication error to assess the cause and any contributing factors such as system or process failures. A record of the quality assurance review shall be immediately retrievable in the pharmacy. The record shall contain at least the following:

1. the date, location, and participants in the quality assurance review;
2. the pertinent data and other information relating to the medication error(s) reviewed and documentation of any patient contact required by subdivision (c);
3. the findings and determinations generated by the quality assurance review; and,
4. recommend changes to pharmacy policy, procedure, systems, or processes, if any. The pharmacy shall inform pharmacy personnel of changes to pharmacy policy, procedure, systems, or processes made as a result of recommendations generated in the quality assurance program.

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20. California Code of Regulations, title 16, section 1714, states:

...

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

...

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

...

21. California Code of Regulations, title 16, section 1716, states:

Pharmacists shall not deviate from the requirements of a prescription except upon the prior consent of the prescriber or to select the drug product in accordance with Section 4073 of the Business and Professions Code. Nothing in this regulation is intended to prohibit a pharmacist from exercising commonly-accepted pharmaceutical practice in the compounding or dispensing of a prescription.

22. California Code of Regulations, title 16, section 1745, states:

...

(b) A "partially filled" prescription is a prescription from which only a portion of the amount for which the prescription is written is filled at any one time; provided that regardless of how many times the prescription is partially filled, the total amount dispensed shall not exceed that written on the face of the prescription.

...

(d) A pharmacist may partially fill a prescription for a controlled substance listed in Schedule II, if the pharmacist is unable to supply the full quantity ordered by the prescriber. The pharmacist shall make a notation of the quantity supplied on the face of the written prescription. The remaining portion of the prescription may be filled within 72 hours of the first partial filling. If the remaining portion is not filled within the 72-hour period, the pharmacist shall notify the prescriber. The pharmacist may not supply the drug after 72 hour period has expired without a new prescription.

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1 23. California Code of Regulations, title 16, section 1761, states:

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

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

10 **FEDERAL REGULATORY AUTHORITY**

11 24. 21 Code of Federal Regulations, part 1306, section 13.06.13 states, in pertinent part:

12 (a) The partial filling of a prescription for a controlled substance listed in Schedule II
13 is permissible if the pharmacist is unable to supply the full quantity called for in a
14 written or emergency oral prescription and he makes a notation of the quantity
15 supplied on the face of the written prescription, written record of the emergency oral
16 prescription, or in the electronic prescription record. The remaining portion of the
17 prescription may be filled within 72 hours of the first partial filling; however, if the
18 remaining portion is not or cannot be filled within the 72-hour period, the pharmacist
19 shall notify the prescribing individual practitioner. No further quantity may be
20 supplied beyond 72 hours without a new prescription.

21 **COSTS**

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

26 **DRUGS**

27 26. Acetaminophen is a Schedule III controlled substance as designated in Health and
28 Safety Code section 11056(e)(2) and is categorized as a dangerous drug pursuant to section 4022
of the Code.

29 27. Alprazolam, sold under the brand name Xanax, is a Schedule IV controlled substance
under Health and Safety Code section 11057 and a dangerous drug under Business and
30 Professions Code Section 4022. Alprazolam is used to treat anxiety disorders and panic disorder.
Alprazolam is in a class of medications called benzodiazepines. Alprazolam comes as a tablet, An
extended-release tablet, and an orally disintegrating tablet. The tablet and orally disintegrating

1 table usually are taken two to four times a day. The extended-release tablet is taken once daily,
2 usually in the morning. Alprazolam may heighten the euphoric effect resulting from the use of an
3 Oxycodone.

4 28. Diazepam, a generic for the brand name Valium, a Benzodiazepam derivative, is a
5 Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(9)
6 and is categorized as a dangerous drug pursuant to section 4022 of the Code.

7 29. Dilaudid is a trade name for Hydromorphone, an Opium derivative, which is
8 classified as a Schedule II Controlled Substance pursuant to Health and Safety Code section
9 11055, subdivision (b)(1), and is a dangerous drug within the meaning of Business and
10 Professions Code section 4022.

11 30. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code
12 section 11055(c)(8) and is a dangerous drug pursuant to Business and Professions Code section
13 4022.

14 31. Hydrocodone is in Schedule II of the Controlled Substances Act. Lortab, Norco and
15 Vicodin, brand/trade names of preparations containing hydrocodone in combination with other
16 non-narcotic medicinal ingredients, are in Schedule III pursuant to Health and safety Code section
17 11056(e)(4), and are categorized as dangerous drugs pursuant to section 4022.

18 32. Methadone, is a synthetic opiate, is a Schedule II controlled substance as designated
19 by Health and Safety Code section 11055(c)(14) and a dangerous drug according to Business and
20 Professions Code section 4022.

21 33. Morphine Sulfate, the narcotic substance is a preparation of Morphine, the principal
22 alkaloid of Opium. It is classified as a Schedule II controlled substance as designated by Health
23 and Safety Code section 11055, subdivisions (b)(1)(L) and (b)(2). It is categorized as a
24 dangerous drug pursuant to Business and Professions Code section 4022.

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1 34. Norco is the brand name for the combination narcotic, Hydrocodone and
2 Acetaminophen, and is a Schedule II¹ controlled substance pursuant to Health and Safety Code
3 section 11055 (b)(1) (I) and is categorized as a dangerous drug pursuant to Business and
4 Professions Code section 4022

5 35. Opana ER is an opioid and schedule II controlled substance.

6 36. Opiates are types of narcotic drugs that act as depressants in the central nervous
7 system. They come from opium, which can be produced naturally from poppy plants or derived
8 from semi-synthetic alkaloids. Some of the most common opiates include morphine, codeine,
9 heroin, hydrocodone and oxycodone. Opiates are pain killers and can produce drowsiness, nausea,
10 constipation and slow breathing.

11 37. Oxycontin, a brand name formulation of oxycodone hydrochloride and/or Oxycodone
12 SR, is an opioid agonist and a Schedule II controlled substance with an abuse liability similar to
13 morphine. OxyContin is for use in opioid tolerant patients only. It is a Schedule II controlled
14 substance pursuant to Health and Safety Code section 11055, subdivision (b)(1), and a dangerous
15 drug pursuant to Business and Professions Code section 4022.

16 38. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code
17 section 11055, subdivision (b)(1)(M) and is a dangerous drug pursuant to Business and
18 Professions Code section 4022. Oxycodone is a narcotic analgesic used for moderate to severe
19 pain and it has a high potential for abuse.

20 39. Suboxone, the brand name of buprenorphine and naloxone, is classified as a Schedule
21 IV controlled substance pursuant to Health and Safety Code section 11058(d), and is a dangerous
22 drug pursuant to Business and Professions Code section 4022. It is used for the treatment of
23 opiate addiction.

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27 ¹ Effective October 6, 2014, the Drug Enforcement Administration rescheduled
28 Hydrocodone combination products from schedule III to schedule II of the Controlled Substances
Act. (See 21 CFR Part 1308 § 1308.12; 21 U.S.C. 812 (c))

1 40. Tranquilizers are central nervous system depressant drugs classified as sedative-
2 hypnotics and are classified into two main categories: minor tranquilizers (anxiolytic, or anti-
3 anxiety agents) and major tranquilizers (neuroleptics) drugs used to treat sever mental illnesses.
4 Minor tranquilizers may include Valium (diazepam), Librium/Novopoxide (chlordiazepoxide),
5 Halcion (triazolam), ProSom (estazolam), Xanax and Ativan.

6 FACTS

7 RESPONDENTS

8 41. Respondent L M Caldwell Pharmacist-State Street and Respondent L M Caldwell
9 Pharmacist-Pueblo Street (collectively Respondents L M Caldwell Pharmacists) are pharmacies
10 operating in the Santa Barbara area.

11 42. Respondent Caldwell is the Pharmacist in Charge at Respondent L M Caldwell
12 Pharmacist-State Street, and Respondent Yahyani was the Pharmacist in Charge at Respondent L
13 M Caldwell Pharmacist- Pueblo Street up to October 1, 2014.

14 43. Pharmacy Technician DLM² was employed at Respondent Caldwell Pharmacist-State
15 Street in 2011.

16 RESPONDENT LM CALDWELL PHARMACIST-STATE STREET AND

17 RESPONDENT CALDWELL

18 Records of Acquisition, Disposition and Storage of Drugs

19 44. Drugs acquired by Respondents L M Caldwell Pharmacist were stored at Respondent
20 L M Caldwell Pharmacists-State Street. Drugs were sent to Respondent L M Caldwell
21 Pharmacist-Pueblo Street as needed. Drug recordkeeping included a transfer document which
22 showed the bottles sent to Respondent L M Caldwell Pharmacist-Pueblo Street. Also, the records
23 for Respondent L M Caldwell Pharmacist-Pueblo Street were located at Respondent L M
24 Caldwell Pharmacist-State Street.

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27 ² Names are not being used to protect identities but individuals will be identified during
28 the course of discovery.

1 45. Between November 15, 2009 and July 13, 2011, Respondent L M Caldwell
2 Pharmacist-State Street and Respondent Caldwell could not account for an inventory overage
3 (disposition greater than acquisition) of 55,370 tablets of Hydrocodone/Acetaminophen (HC/AP)
4 10/325 mg and 165 tablets of Oxycodone SR 80 mg. Between August 6, 2011 and January 15,
5 2013, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not
6 account for an inventory overage of 78,746 tablets of HC/AP 10/325 mg.

7 46. Between January 5, 2010 and January 15, 2013, Respondent L M Caldwell
8 Pharmacist -State Street and Respondent Caldwell could not account for prescription hardcopies
9 for Prescriptions Nos. 793824, 793825, 793826, 789177, 789188, 793189, 793190, 805552,
10 782075, 792283, 793432, 793184, 791387, 797610, 787609, 790594, 790595, 790597, 795658,
11 804361, 792346, 793090, 795652, 776675, 773787, 779441, 780927, 790980, 792044, 792920,
12 792935 and 792928.

13 Operational Standards and Security

14 47. Respondent Caldwell was responsible for the security and record keeping at
15 Respondents L M Caldwell Pharmacists. Between November 15, 2009 to July 13, 2011,
16 Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account
17 for the loss of 5,360 tablets of Hydromorphone 8 mg. Between August 6, 2011 to January 15,
18 2013, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not
19 account for the loss of 8,800 tablets of Hydromorphone 8 mg and for the loss of 605 tablets of
20 Oxycodone 30 mg.

21 48. Respondents L M Caldwell Pharmacists and Respondent Caldwell failed to maintain
22 an effective control of the security of the prescription department against theft or loss of
23 controlled substances/ dangerous drugs.

24 Furnishing and Purchasing of Dangerous Drugs or Devices Without Adequate

25 Sales and Purchase Records

26 49. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell
27 Pharmacist-State Street and Respondent Caldwell sold HC/AP 10/325 mg to Respondent L M
28 Caldwell Pharmacist- Pueblo Street without adequate sales records.

1 **Prescriptions Dispensed by L M Caldwell Pharmacist- State Street and**
2 **Respondent Caldwell**

3 50. Between January 1, 2011 and December 5, 2012, Respondent L M Caldwell
4 Pharmacist-State Street and Respondent Caldwell, dispensed a total of 11,817 controlled
5 substance prescriptions of which 1,492 were prescriptions written by Dr. Julio Gabriel Diaz, a
6 family practice prescriber. The prescriptions were dispensed without regard to the following
7 factors:

8 (1) Pattern of patients willing to drive long distance to obtain controlled substance
9 prescriptions from Dr. Diaz and to fill the prescriptions at L M Caldwell Pharmacists and other
10 pharmacies;

11 (2) Percentage of cash patients specific to listed prescribers and pattern of patients
12 willing to pay cash for highly expensive prescriptions when insurance did not cover;

13 (3) Same or similar prescribing patterns for multiple patients, including at least three
14 opiates and one to two tranquilizers;

15 (4) Irregular pattern of early refills/ patient returning too frequently.

16 51. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell failed
17 in their corresponding responsibility to appropriately scrutinize patients' drug therapy with readily
18 available tools such as CURES³ reports and its own pharmacy records. Respondents did not
19 have a process to validate prescriptions. As a result, they repeatedly dispensed controlled
20 substances early in certain instances to patients who habitually engaged in doctor shopping and
21 multiple pharmacy activity. Questionable drug therapies were visible from Respondent L M
22 Caldwell-State Street's own records and showed the prescribing pattern of Dr. Diaz was repetitive
23 and redundant with respect to the same controlled substances prescribed repeatedly for the

24 ³ CURES is an acronym for "California Utilization Review and Evaluation System." It
25 contains over 100 million entries of controlled substance drugs that were dispensed in California.
26 Pharmacists and prescribers can register with the Department of Justice to obtain access to the
27 CURES data through the California Prescription Drug Monitoring Program (PDMP). Patient
28 Activity Reports (PARs) are provided and reflect all controlled substances dispensed to an
individual. CURES herein refers to CURES in general and PARs. Pharmacies are required to
report to the California Department of Justice every schedule II, II and IV drug prescription under
Health and Safety Code section 1165, subdivision (d).

1 majority of his patients. His prescribing habits included numerous large quantities of opiates in
2 combination with minor tranquilizers. Patients received on average three to four pain
3 medications with one to two anti-anxiety drugs. The patients included, but were not limited to,
4 VA, BA, KB, CD, LD, TF, JH, MM, AM, SM, SS, JS, NS, VS, and CW. A review of CURES
5 and their own records would have been a red flag for Respondents. For example:

6 a. Patient VA went to 4 prescribers and 18 pharmacies from January 1, 2009 to April 8,
7 2013, including in Santa Maria, Arleta, Santa Barbara and Ventura. He lived in Oxnard and
8 traveled approximately 37.34 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-
9 State Street was approximately 39.67 miles from Patient VA's home and 1.85 miles from Dr.
10 Diaz's office. Patient VA paid cash for his prescriptions. Review of CURES showed therapy
11 duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr.
12 Diaz while having prescriptions dispensed at Respondent LM Caldwell Pharmacist- State Street.
13 Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. He
14 received numerous prescriptions for HC/AP 10/325 mg and Methadone prescribed by Dr. Diaz on
15 or around the same time he had them dispensed at different pharmacies. In the month of August
16 2010, for example, Patient VA received 960 tablets of HC/AP 10/325 mg within 30 days. He
17 received 10,400 mg per day, well above the recommended dose of (Acetaminophen) per day of
18 4,000 mg per day. In July of 2011, for example, Patient VA received 1,080 tablets of HC/AP
19 10/325 mg within 30 days. Patient VA received 13,000 mg per day. In January of 2011, for
20 example, Patient VA received a 30 day supply of Methadone 10 mg from one pharmacy and then
21 received another 30 day supply from another pharmacy, LM Pharmacist-State Street, ten days
22 later on, January 25, 2011;

23 b. Patient BA only saw one prescriber, Dr. Diaz, and went to 12 pharmacies from
24 January 1, 2009 to April 8, 2013. He lived in Ventura and traveled approximately 31.53 miles to
25 Santa Barbara to see prescriber Dr. Diaz. Respondent LM Caldwell-State Street was
26 approximately 33.86 miles from Patient BA's home and 1.85 miles from Dr. Diaz's office.
27 Patient BA paid cash for his prescriptions. Review of CURES showed therapy duplication based
28 on the number of opiates and tranquilizers dispensed. Patient BA received numerous prescriptions

1 for HC/AP 10/325 mg and Methadone prescribed by Dr. Diaz on or around the same time he had
2 them dispensed at different pharmacies. Most pain medication was prescribed by Dr. Diaz,
3 despite him not being a pain specialist. In March of 2010, for example, Patient BA received 1200
4 tablets of HC/AP 10/325 within 30 days. He received 13,000 mg per day of Acetaminophen, well
5 above the recommended dose of 4,000 mg per day. In February of 2011, for example, Patient BA
6 received 720 tablets of HC/AP 10/325. He received 7800 mg per day of Acetaminophen;

7 c. Patient KB saw 5 prescribers and went to 11 pharmacies from January 1, 2009 to
8 April 8, 2013, including in Carpinteria, Hollywood, Lompoc, Santa Barbara and Solvang. He
9 lived in Santa Inez and traveled approximately 31.99 miles to Santa Barbara to see prescriber Dr.
10 Diaz. Respondent LM Caldwell-State Street was approximately 29.10 miles from Patient VA's
11 home and 1.85 miles from Dr. Diaz's office. Patient VA paid cash for his prescriptions. Review
12 of CURES showed therapy duplication based on the number of opiates and tranquilizers
13 dispensed. He received most pain medication from Dr. Diaz, despite him not being a pain
14 specialist. Patient KB was dispensed 595 tablets of Oxycodone 30 mg in one month in
15 Prescriptions 788268, 788632 and 789490. Patient KB, for example, was dispensed Oxycodone
16 30 mg at both Respondent L M Caldwell- State Street and at Respondent L M Caldwell- Pueblo
17 Street on June 18, 2010, October 5, 2010, November 2, 2010 and November 29, 2010. Patient
18 KB was placed on Suboxone, used for the treatment of narcotic addiction, prior to going to LM
19 Caldwell Pharmacists- State Street;

20 d. Patient LD saw 4 prescribers and went to 2 pharmacies from January 1, 2009 to April
21 8, 2013, including in Carpinteria, Hollywood, Lompoc, Santa Barbara and Solvang. Patient LD
22 lived in Santa Barbara and paid cash for his prescriptions. Review of CURES showed therapy
23 duplication based on the number of opiates and tranquilizers dispensed. He received most pain
24 medication from Dr. Diaz, despite him not being a pain specialist. While going to Respondent
25 LM Caldwell Pharmacist-State Street, Patient LD mainly saw Dr. Diaz but saw two prescribers
26 after Dr. Diaz. Several questionable prescriptions were filled including: Prescription No.
27 773360(HC/AP) and 773361 (HC/ibuprofen) which were both dispensed on September 21, 2010
28 and both had hydrocodone; Prescription Nos. 789181 (HC/ Ibuprofen), 789182

1 (Oxycodone/Ibuprofen) and 789180 (Oxycodone) were all dispensed on August 23, 2011 and
2 contained the same drugs; and Prescription Nos. 790459, 790460 and 790458 had dates that were
3 not written in the prescriber's handwriting; Prescription No. 792432 (Lorazepam) was for a large
4 quantity of 300 pills and Respondent dispensed 120 pills and did not verify with the prescribers;

5 e. Patient TF saw 1 prescriber, Dr. Diaz, and went to 8 pharmacies January 1, 2009 to
6 April 8, 2013, including in Lompoc, Goleta, San Luis Obispo, Santa Maria and Orcutt. He lived
7 in Santa Barbara and paid cash for his prescriptions Review of CURES showed therapy
8 duplication based on the number of opiates and tranquilizers dispensed;

9 f. Patient JH saw 4 prescribers and went to 12 pharmacies from February 13, 2009 to
10 April 8, 2013. He saw prescribers in Santa Barbara, Lompoc and Temecula and went to
11 pharmacies in Santa Maria, Santa Barbara, Temecula, Buelton, and Lompoc. He lived in Santa
12 Maria and traveled approximately 61.53 miles to Santa Barbara to see prescriber Dr. Diaz.
13 Respondent LM Caldwell-State Street was approximately 58.68 miles from Patient JH's home
14 and 1.85 miles from Dr. Diaz's office. Patient JH paid cash for his prescriptions. Review of
15 CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed.
16 He received only pain medication from Dr. Diaz, despite him not being a pain specialist. He did
17 not have significant pain history one month prior to February 2009 and had a history of Anxiety 8
18 months prior to August 2009 and before seeing Dr. Diaz. Respondent LM Caldwell Pharmacist-
19 State Street should have questioned the following prescriptions dispensed to Patient JH on
20 November 25, 2011: Prescription Nos. 793748 (Morphine Sulfate 30 mg), 793749 (Methadone 10
21 mg), 793750 (HC/AP 10/325 mg), 793751 (Oxycodone 30 mg), 793756 (Hydromorphone 8 mg),
22 793757 (Alprazolam 2 mg). Records also show that the quantity and therapy duplication
23 combination was reduced from November 30, 2009 to September 22, 2010, during the period that
24 JH did not go to Dr. Diaz. He again began to receive large quantities and therapy duplication
25 combinations when he went back to Dr. Diaz on September 30, 2010.

26 g. Patient MM saw 19 prescribers and went to 20 pharmacies from January 1, 2009 to
27 April 8, 2013. She went to prescribers in Santa Barbara, Lompoc, Stanford, Encinitas, Santa
28 Maria, Solvang, San Luis Obispo and San Francisco and went to pharmacies in Santa Barbara,

1 Lompoc, Orcutt, San Luis Obispo, Pismo Beach, Buelton, and Santa Maria. He lived in Lompoc
2 and traveled approximately 56.30 miles to Santa Barbara to see prescriber Dr. Diaz. Respondent
3 LM Caldwell-State Street was approximately 53.69 miles from Patient MM's home and 1.85
4 miles from Dr. Diaz's office. Patient MM paid cash and paid through insurance for his
5 prescriptions. For example, he paid \$2,585.80 for Oxycontin 60 mg (Prescription No. 319145).
6 Review of CURES showed therapy duplication based on the number of opiates and tranquilizers
7 dispensed. MM received numerous prescriptions for Oxycontin prescribed by Dr. Diaz on or
8 around the same time and went to different pharmacies to get dispensed, including LM Caldwell
9 Pharmacist- Pueblo Street;

10 h. Patient SM saw 7 prescribers and went to 11 pharmacies from January 1, 2009 to
11 April 8, 2013, including L M Caldwell- Pueblo Street. He lived in Santa Barbara and paid cash
12 for his prescriptions. Review of CURES showed therapy duplication based on the number of
13 opiates and tranquilizers dispensed. Respondent L M Caldwell- State Street dispensed
14 questionable prescriptions for Oxycodone in which instructions for use seemed too high
15 (including receiving 16-24 tablets per day), including Prescription Nos. 782797, 777041, 789979
16 and 786575. Patient SM was placed on Suboxone, used for the treatment of narcotic addiction,
17 after no longer seeing Dr. Diaz. SM received only pain and anxiety medication from Dr. Diaz,
18 despite him not being a pain specialist;

19 i. Patient SS saw 2 prescribers and went to 4 pharmacies from January 1, 2009 to April
20 8, 2013. He lived in Santa Barbara and paid cash for his prescriptions when insurance did not
21 cover the cost. Review of CURES showed therapy duplication based on the number of opiates
22 and tranquilizers dispensed. He showed no significant pain or anxiety history prior to
23 11/23/2010. L M Caldwell- State Street dispensed the following questionable prescriptions:
24 Prescription Nos. 780807 and 783547 for Fentanyl patches above the recommended dosing
25 interval of 72 hours. The pharmacy dispensed it for every 48 hours; Prescription Nos. 79027,
26 790597, 782251, and 782250 in which the patient received Diazepam 10 mg and Alprazolam 2
27 mg at the same time. Patient SS received most pain medication from Dr. Diaz, despite him not
28 being a pain specialist;

1 j. Patient JS saw 4 prescribers and went to 4 pharmacies from January 1, 2009 to April
2 8, 2013. He lived in Lompoc and traveled approximately 55.98 miles to Santa Barbara to see
3 prescriber Dr. Diaz. Respondent LM Caldwell-State Street was approximately 53.37 miles from
4 Patient JH's home and 1.85 miles from Dr. Diaz's office. Patient JS had the same address as
5 Patient NS. Review of CURES showed therapy duplication based on the number of opiates and
6 tranquilizers dispensed. Prior to going to Respondent LM Caldwell Pharmacist-State Street,
7 Patient JS went to multiple pharmacies for Dr. Diaz's prescriptions. There was no significant pain
8 history 6 months prior to June 18, 2009 and Dr. Diaz. Patient JS received only pain and anxiety
9 medication from Dr. Diaz, despite him not being a pain specialist;

10 k. Patient NS saw 3 prescribers and went to 5 pharmacies from January 1, 2009 to April
11 8, 2013. He lived in Lompoc and traveled approximately 55.98 miles to Santa Barbara to see
12 prescriber Dr. Diaz. Respondent LM Caldwell-State Street was approximately 53.37 miles from
13 Patient NS's home and 1.85 miles from Dr. Diaz's office. Patient NS had the same address as
14 Patient JS. Patient NS paid cash for his prescriptions when the cost was not covered by insurance.
15 Review of CURES showed therapy duplication based on the number of opiates and tranquilizers
16 dispensed. Prior to going to Respondent LM Caldwell Pharmacist-State Street, Patient JS went to
17 multiple pharmacies for Dr. Diaz's prescriptions. While going to L M Caldwell Pharmacist- State
18 Street, he continued to use other pharmacies. Patient NS received only pain and anxiety
19 medication from Dr. Diaz, despite him not being a pain specialist;

20 l. Patient VS saw 3 prescribers and went to 5 pharmacies from January 1, 2009 to April
21 8, 2013, including Respondent LM Caldwell Pharmacist-State Street. He lived in Lompoc a and
22 traveled approximately 55.47 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-
23 State Street was approximately 52.86 miles from Patient VS's home and 1.85 miles from Dr.
24 Diaz's office. Patient VS paid cash for his prescriptions when the cost was not covered by
25 insurance. Patient VS paid over \$200.00 for Oxycodone several times. Review of CURES
26 showed therapy duplication based on the number of opiates and tranquilizers dispensed. Patient
27 VS went to multiple pharmacies for Dr. Diaz's prescriptions. Respondent L M Caldwell - State
28 Street dispensed the following questionable prescriptions: Hydromorphone 8 mg and

1 Hydromorphone 4 mg were dispensed on January 1, 2011, February 2, 2011, March 2, 2011,
2 March 30, 2011 and April 27, 2011. Oxycodone 30 mg and Oxycodone 5 mg was dispensed on
3 April 27, 2011. The different strength of the prescriptions should have been red flags. Patient
4 VS received only pain and anxiety medication from Dr. Diaz, despite him not being a pain
5 specialist;

6 m. Patient CW saw 2 prescribers and went to 2 pharmacies from January 1, 2009 to April
7 8, 2013. Patient CW lived in Santa Barbara and paid cash when the cost was not covered by
8 insurance. Review of CURES showed therapy duplication based on the number of opiates and
9 tranquilizers dispensed. Respondent L M Caldwell- State Street dispensed questionable
10 prescriptions, including the following: Amphetamine 30 mg and Amphetamine 20 mg dispensed
11 at same time in Prescription Nos. 772453, 772454, 773785, 773783, 775368, 775363, 776678,
12 776679, 780924, 780923, 779437, 779438, 771122 and 771123 and Suboxone was prescribed by
13 Dr. Diaz for pain on numerous occasions. Patient CW received mostly pain, and anxiety
14 medications prescribed by Dr. Diaz, despite him not being a pain specialist.

15 52. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell did not
16 know the diagnosis for patients VA, BA, KB, CD, LD, TF, JH, MM, AM, SM, SS, JS, NS, VS,
17 and CW, and knew that Dr. Diaz was a family practitioner and not a pain management physician.
18 Also, L M Caldwell Pharmacist-State Street and Respondent Caldwell failed to maintain records
19 or files on drug therapy for these patients.

20 53. When reviewing the records for patients VA, BA, KB, CD, LD, TF, JH, MM, AM,
21 SM, SS, JS, NS, VS, and CW, it was noted that nine out of these fifteen patients lived outside Dr.
22 Diaz's and Respondent LM Caldwell Pharmacist-State Street's normal trading area . Due to the
23 number of readily accessible pharmacies throughout California, the common trading area is
24 considered to be 5.miles. The range of distance travelled for the selected patients was between
25 3.7 miles for the shortest to 122.06 for the longest. The average distance traveled by the patient
26 was 59.18 miles and the total distance these patients travelled to obtain controlled substances was
27 excessive. Four of the fifteen patients' home addresses were not recognized by Mapquest. Two
28 patients had the same address, NS and JS.

1 54. Respondent LM Caldwell Pharmacist-State Street dispensed a total of 11,817
 2 controlled substances prescriptions from January 1, 2011 to December 5, 2012 and 1,492 were
 3 prescribed by Dr. Diaz. 31.64 % (407 out of 1,492) of Dr. Diaz' patients paid cash, including
 4 when the medication was not covered by their insurance or to get early refills. Some patients had
 5 insurance/Medicaid, however, were willing to pay a large sum of cash for controlled substances
 6 which were not covered by the plans, including those on Medicaid.

7 55. There was excessive furnishing of controlled substances prescribed by Dr. Diaz. The
 8 dispensing ratio of prescriptions by Dr. Diaz by Respondent L M Caldwell Pharmacists-State
 9 Street and Respondent Caldwell was greatly unbalanced when compared to other neighboring
 10 pharmacies, including the following three pharmacies: Federal Drugs PHY37078 (located 1.92
 11 miles from L M Caldwell Pharmacist-State Street), Rite-Aid #5785 PHY 42255 (located 1.65
 12 miles from L M Caldwell Pharmacist-State Street), and CVS#9392 PHY 494473 (located .41
 13 miles from L M Caldwell Pharmacist-State Street). Respondent L M Caldwell Pharmacist-State
 14 Street filled tens of thousands more controlled substances prescribed by Dr. Diaz when compared
 15 to neighboring pharmacies for the time period specified of January 1, 2011 through December 5,
 16 2012. The CURES data for the Respondent L M Caldwell Pharmacists-State Street and three
 17 surrounding pharmacies, for example, was as follows:

Pharmacy	Total controlled substances dispensed between 1/1/2011-12/5/2012	Total Dr. Diaz's RX from 1/1/2011-12/5/2012	Total quantity for Dr. Diaz's RX from 1/1/2011-12/5/2012	% of total controlled substance RX dispensed for Dr. Diaz
Respondent LM Caldwell Pharmacist – State Street	11, 817	1,492	195,041	12.62%
Federal Drugs PHY 37078 (1.92 miles from LM Caldwell)	18, 282	0	0	0%
Rite-Aid #5785 PHY 42255 (.065 miles from LM Caldwell)	3,584	0	0	0%

Pharmacist				
CVS # 9392 PHY 49473 (.41 miles from LM Caldwell)	13,365	44	6,599	.33%

Pattern of Early Refills and Duplicate Medications

56. Between January 1, 2010 and December 5, 2012, Respondent LM Caldwell- State Street and Respondent Caldwell engaged in a pattern of early refills, including for patients KB, CD, LD, TF, JH, AM, SM, NS, VS, and CW, including, for example, 23 days early for patient LD (prescription Nos. 764100 & 764468), 29 days early for patient AM (prescription Nos. 791702 & 793219), 21 days early for patient SM (prescription Nos. 786128 & 786573), and 14 days early for patient CW (prescription Nos. 782792 & 782792).

57. Also, the patient profile from 2010 to 2012 for patient SS,⁴ for example, showed numerous therapy duplicate medications prescribed by Dr. Diaz and dispensed by L M Caldwell Pharmacists- State Street and Respondent Caldwell⁵. The profile showed the following:

a. On January 18, 2011, when L M Caldwell Pharmacists-State Street started dispensing Fentanyl 100 mcg/hr to Patient SS (Prescription No. 778213), the pharmacists should have questioned the high doses of Fentanyl and whether Patient SS was previously on Fentanyl 100 mcg/hr prior to getting his prescription from L M Caldwell Pharmacist-State Street;

b. Patient SS was prescribed Methadone 3 tablets every twelve (12) hours on July 19, 2011 and on August 17, 2011 (Prescription Nos. 787609 & 788989) and each month thereafter, his dose was increased, four (4) tablets every twelve (12) hours on September 22, 2011 (Prescription No. 790594), and five (5) tablets every 12 hours on October 27, 2011 (Prescription No. 792268);

///

⁴ Patient SS died in May 2012 allegedly as a result of a drug overdose.

⁵ No prescriptions were dispensed by Respondent L M Caldwell-State Street or Respondent Caldwell for Patient SS from January 10, 2010 to December 30, 2010.

1 c. On March 15, 2011, ten (10) patches of Fentanyl 100 mcg/hr were dispensed, each
2 for a thirty (30) day supply (Prescription No. 780807). Seven days later, on March 22, 2011,
3 another 10 patches of Fentanyl 100 mcg/hr were prescribed and entered as a file only as "FO"
4 (Prescription No. 782067);

5 d. On March 22, 2011, Prescription No. 784841 for Morphine Sulfate 10 mg/5ml
6 solution was written with no quantity written on the prescription, but the quantity box of "151 &
7 over" was marked and 360 mls were dispensed by Respondent L M Caldwell-State Street and
8 Respondent Caldwell. This prescription was incomplete and the prescriber, Dr. Diaz, should have
9 been contacted and the quantity documented after clarification from the prescriber;

10 e. On May 20, 2011, Patient SS was prescribed three different narcotic pain
11 medications: Hydromorphone 8 mg one tablet daily (Prescription No. 784840) with Fentanyl 100
12 mcg/hour patch every forty-eight (48) hours (Prescription No. 784839) and Morphine Sulfate 10
13 mg, 5ml every two (2) to four (4) hours (Prescription No. 784841). Prescription No. 784839 was
14 dispensed by Respondent L M Caldwell-State Street and Respondent Caldwell, for Fentanyl 100
15 mcg/hour with directions to apply every forty-eight (48) hours. However, the manufacturer's
16 direction was to change the patch every seventy-two (72) hours;

17 f. On July 18, 2011, Prescription No. 787610 for Morphine 20 mg/ml solution was
18 written for 400 mls, but 360 mls was dispensed. This was a variation from the quantity
19 prescribed;

20 **Exceeding the Day Supply For Controlled Substance Refills**

21 58. The patient profile from 2010 to 2012 for patient SS, also showed that the day supply
22 was exceeded for controlled substance refills, for example, as follows:

23 a. A review of SS patient profile revealed that alprazolam and diazepam, classified as
24 benzodiazepines were also dispensed by LM Caldwell Pharmacist-State Street and Respondent
25 Caldwell from December 2010 to September 2011. Prescription No. 782251 for Alprazolam, a
26 Schedule IV controlled substance, was originally dispensed on March 25, 2011 for a 30 day
27 supply. Prescription No. 782251 was then refilled five times, each for a 30 day supply, on April
28 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011 by Respondent L M

1 Caldwell-State Street and Respondent Caldwell. A total of 150-day supply was dispensed,
2 exceeding a 120-day supply as required by Health and Safety code section 11200;

3 b. Prescription No. 782250 for Diazepam, a schedule IV controlled substance, was
4 originally dispensed on March 25, 2011 then refilled five times, each for a 30 day supply, on
5 April 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011 by Respondent
6 L M Caldwell-State Street and Respondent Caldwell. A total of 150-day supply was dispensed,
7 exceeding a 120-day supply as required by Health and Safety code section 11200.

8 **Patient JJ**

9 59. On September 12, 2013, the Board received a report of settlement judgment or
10 arbitration award, San Bernardino Superior Court, Case No. 2012-112565, regarding Patient JJ,
11 from Liberty Insurance Underwriter, Inc. for Respondent Caldwell, without the admission of
12 guilt. Improper Management and dispensing of controlled substance resulting in addiction and
13 death was alleged in the civil suit. Patient JJ presented prescriptions from a medical doctor
14 which Respondent Caldwell dispensed. Patient JJ alleged that she became addicted to drugs
15 because Respondent Caldwell dispensed the prescriptions to her.

16 60. A review of Respondent L M Caldwell Pharmacists-State Street's profile for Patient
17 JJ revealed that she was mostly dispensed controlled substances by Respondent Caldwell which
18 were prescribed by Dr. Diaz, who was not a pain specialist. A review of CURES revealed that
19 Patient JJ went to multiple doctors at the same time and had prescriptions dispensed at multiple
20 pharmacies during the same time period. Patient JJ received numerous refills and received above
21 the recommended dose of 400 mg per day of Acetaminophen. On certain months, Patient JJ
22 received over 600 tablets of Hydrocodone. If Respondent Caldwell would have checked
23 CURES, he would been able to determine JJ was going to several pharmacies and several doctors.
24 Respondent Caldwell knew that patient was getting drugs from Dr. Diaz, prior to being indicted,
25 and then continued to dispense prescriptions from other doctors to this patient.

26 61. Patient JJ had a pattern of early refills on Oxycodone 30 mg, for the management of
27 moderate to severe pain, and Morphine Sulfate 30 mg, for the management of severe pain. Both
28 medications are for the immediate relief of pain. LM Caldwell Pharmacist-State Street and

1 Respondent Caldwell failed to contact the prescriber to determine the logic of this combination.
2 Also, Prescription Nos. 768630 and 768631 were dated July 1, 2010. LM Caldwell Pharmacist-
3 State Street and Respondent Caldwell received and dispensed them on June 11, 2010.

4 62. From January 1, 2010 to January 1, 2013, Patient JJ had 145 prescriptions for
5 controlled substances dispensed from various prescribers and pharmacies. 85 of the 145
6 prescriptions (58.96 %) were for cash.

7 63. From January 1, 2010 to January 1, 2013, LM Caldwell Pharmacist-State Street and
8 Respondent Caldwell failed to assume their corresponding responsibility when they failed to
9 appropriately scrutinize Patient JJ's drug therapy with readily available tools such as CURES
10 reports and its own pharmacy records. Respondents should have looked at the repetitive
11 prescribing pattern for highly abused controlled substances, the location of prescriber's practice in
12 relation to the location of JJ's residence, and Patient's payment methods. As a result,
13 Respondents dispensed controlled substances for Patient JJ who was habitually engaged in doctor
14 shopping and multiple pharmacy activity. Respondents should have questioned the legitimacy of
15 Prescriptions, including Prescription Nos. 758920, 767530, 767531, 768630, 768631, 758920 (for
16 1/18/2010, 3/19/2010, 2/18/2011, 2/18/2011), 782598 (for 4/1/2011, 5/17/2011), 803536, 803537,
17 803963,803965, 803966, 805071, 805072, 805074, 806756, 806757, 807683, 807684, 807699
18 and 807700.

19 **Patient AM**

20 64. On February 3, 2014, the Board received a report of settlement judgment or
21 arbitration award, Case No. 1414079, regarding Patient AM, from Chicago Insurance Company
22 for Respondent Caldwell- State Street, without the admission of guilt. Patient AM, presented a
23 prescriptions from a medical doctor which Respondent Caldwell dispensed. On November 25,
24 2011, Patient AM died from acute complications from narcotic abuse.

25 65. A review of Respondent L M Caldwell Pharmacist-State Street's profile for Patient
26 AM revealed that Patient AM received the following controlled substances, that were prescribed
27 by Dr. Diaz, at LM Caldwell Pharmacists-State Street, and had a pattern of being dispensed early:
28

RX Dispensed	RX #	QTY	Day Supply	Date dispensed	RX#	QTY	Day Supply	Days Early from Prior RX
10/24/11	792077	120	30	11/14/11	793124	120	30	9 days
11/14/11	793104	150	19	11/15/11	793216	90	30	19
11/15/11	793105	150	19	11/15/11	793218	90	30	19
11/15/11	791702	120	30	11/15/11	793219	60	20	29

66. The Board could not find the exact patient address on Mapquest in Solvang, California. Patient AM traveled 35.56 miles from Solvang to Santa Barbara where Dr. Diaz was located. Patient AM lived approximately 70.09 miles away from Respondent LM Caldwell-State Street. Patient AM paid cash for his medication and Dr. Diaz was the prescriber. Respondents did not have access to CURES during the time Dr. Diaz dispensed to AM so it was not accessed. The pharmacy did not have a process to validate the prescriptions. As long as the Dr. wrote the prescription, the pharmacy dispensed it.

67. A review of Respondent L M Caldwell Pharmacist-Pueblo Street's profile for Patient AM and CURES records also revealed that Patient AM saw 4 prescribers and went to 8 pharmacies from January 1, 2009 to April 8, 2013. Patient AM saw prescribers in Santa Barbara, Solvang, and Shell Beach. Patient AM received only pain medication from Dr. Diaz, despite him not being a pain specialist.

68. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell would have been able to determine there were unusual prescribing patterns for Dr. Diaz and that Patient AM was going to multiple pharmacies. While going to Respondent L M Caldwell Pharmacist-State Street, Patient AM went to multiple pharmacies and received multiple prescriptions for Hydrocodone 8 mg on or around the same time from Dr. Diaz which AM dispensed at different pharmacies. For example:

a. On February 23, 2010, he received Hydrocodone (#60-5 day supply) dispensed at Sansum Clinic, Prescription No. 2272072, and Hydrocodone (#200-17 day supply) at The Medicine Shoppe Prescription No. 1142240;

1 b. On October 14, 2010, he received Hydrocodone (#60-4 day supply) dispensed at
2 Sansum Clinic, Prescription No. 2277704, and Hydrocodone (#260-21 day supply) at Respondent
3 LM Caldwell Pharmacists-Pueblo Street, Prescription No. 322231;

4 c. On January 5, 2011, he received Hydrocodone (#180-16 day supply) dispensed at
5 Respondent LM Caldwell Pharmacist-Pueblo Street, Prescription No. 324789, and on January 7,
6 2011, he received Hydrocodone (#180-30 day supply) at LM Caldwell Pharmacists-State Street,
7 Prescription No. 778577;

8 d. On November 11, 2011, he received Hydrocodone (#120-15 day supply) dispensed at
9 Respondent LM Caldwell Pharmacist-Pueblo Street, Prescription No. 609846. On November 14,
10 2011, he received Hydrocodone (#150- 19 day supply) at LM Caldwell Pharmacists-State Street,
11 Prescription No. 793104. On November 15, 2013, he received Hydrocodone (#90-30 day supply)
12 dispensed at LM Pharmacist -- State Street, Prescription No. 793216.

13 69. While going to Respondent L M Caldwell Pharmacist --State Street, Patient AM went
14 to multiple pharmacies and received multiple prescriptions for Oxycodone 30 mg on or around
15 the same time from Dr. Diaz which Patient AM had dispensed at different pharmacies. For
16 example:

17 a. On July 21, 2010 he received Oxycodone (#60-15 day supply) dispensed at Sansum
18 Clinic Pharmacy, Prescription No. 2275679 and on July 26, 2010 he received Oxycodone (#60-
19 15 day supply) dispensed at L M Caldwell Pharmacist - State Street, Prescription No. 770660;

20 b. On January 5, 2011, he received Oxycodone (#180-15 day supply) dispensed at
21 Respondent LM Caldwell Pharmacist-State Street, Prescription No. 324788, and on January 7,
22 2011, he received Oxycodone (#180-15 day supply) at LM Caldwell Pharmacists-State Street,
23 Prescription No. 778578;

24 c. On November 11, 2011, he received Oxycodone (#97-12 day supply) dispensed at
25 San Ysidro Pharmacy, Prescription No. 609848. On November 14, 2011, he received Oxycodone
26 (#150- 19 day supply) at Respondent LM Caldwell Pharmacists-State Street, Prescription No.
27 793105. On November 15, 2013, he received Oxycodone (#90-30 day supply) dispensed at
28 Respondent LM Pharmacist -- State Street, Prescription No. 793218.

1 **RESPONDENT LM CALDWELL PHARMACIST-PUEBLO STREET AND**
2 **RESPONDENT YAHYAVI**

3 **Records of Acquisition, Disposition and Storage of Drugs**

4 70. Between December 18, 2010 and December 17, 2012, Respondent L M Caldwell
5 Pharmacist-Pueblo Street and Respondent Yahyani could not account for an inventory overage of
6 53,811 tablets of HC/AP 10/325 mg.

7 71. On January 16, 2013, Respondent LM Caldwell Pharmacist - Pueblo Street and
8 Respondent Yahyavi were unable to provide the original prescription documents for RX #
9 327435, 334405, 317892, 317893, 317894, 330297, 323526, 324203, 325803, 325881, 312027,
10 316180, 315861, 322717, 322718, 319209, 322715, 330610, 333178, 334336, 318220, 331648,
11 322460, 332461, 326892, 327949, 332102, and 336005.

12 **Furnishing and Purchasing of Dangerous Drugs or Devices Without Adequate**
13 **Sales and Purchase Records**

14 72. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell
15 Pharmacist-Pueblo Street purchased HC/AP 10/325 mg from Respondent L M Caldwell
16 Pharmacist-State Street without adequate purchase records.

17 **Variation from Prescription Without Prior Consent of Prescriber**

18 73. Review of prescriptions from January 1, 2010 to January 15, 2013 revealed that
19 Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi deviated from the
20 requirements of a prescription without the prior consent of the prescriber. Specifically, between
21 January 1, 2010 and January 15, 2013, they dispensed the following prescriptions incorrectly:

22 a. Prescription No. 321310, was for Oxycodone 30 mg 1-2 every 6 hour as needed for
23 pain. Respondents dispensed it as 1 tablet four times daily as needed for pain;

24 b. Prescription No. 321312, was for Xanax mg 1-2 times daily for panic. Respondents
25 dispensed it as 1 tablet four times daily;

26 c. Prescription No. 325038, was for 30 mg 1-2 HC/AP 7.5/750 mg. Prescriber wrote 1
27 tablet every 6 hours as needed for pain and Respondents dispensed it as 1 tablet every 4-6 hours
28 as needed for pain;

1 d. Prescription No. 331728, was for Dilaudid 8 mg, 1 every 6 hours #120. Respondents
2 dispensed Hydromorphone 8 mg, 1-2 tablets every 6 hours;

3 e. Prescription No. 332908, was for Methadone 10 mg 7 tablets every 12 hours #400.
4 Respondents dispensed it as 6 tablets every 12 hours;

5 f. Prescription No. 335645, was for Oxycodone IR 30 mg 1 tablet every 4-6 hour.
6 Respondents dispensed Oxycodone IR 30 mg 1 tablet every 6 hours.

7 **Dispensing The Balance of Schedule II Prescriptions Beyond 72 hours**

8 74. Review of prescriptions, from January 1, 2010 to January 15, 2013, revealed that
9 Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi partially filled
10 prescriptions for controlled substances listed in Schedule II and then dispensed the balance of the
11 prescription after the 72 hour period allowed for dispensing the balance of prescriptions.
12 Specifically between January 1, 2010 to January 15, 2013, Respondents dispensed Prescription
13 Nos. 329771, 331396, 332230, and 33265, then dispensed the balance of the prescriptions after 72
14 hours.

15 **Prescriptions Dispensed by Respondent L M Caldwell Pharmacist- Pueblo Street**
16 **and Respondent Yahyavi**

17 75. Between January 1, 2011 and December 5, 2012, L M Caldwell Pharmacist-Pueblo
18 Street and Respondent Yahyavi dispensed at total of 11,215 controlled substance prescriptions of
19 which 1,418 prescriptions were written by Dr. Diaz. The prescriptions were dispensed without
20 regard to the following factors:

21 (1) Pattern of patients willing to drive long distance to obtain controlled substance
22 prescriptions from Dr. Diaz and to fill the prescriptions at L M Caldwell Pharmacists and other
23 pharmacies;

24 (2) Percentage of cash patients specific to listed prescribers and pattern of patients
25 willing to pay cash for highly expensive prescriptions when insurance did not cover;

26 (3) Same or similar prescribing patterns for multiple patients, including at least three
27 opiates and one to two tranquilizers;

28 (4) Irregular pattern of early refills/ patient returning too frequently.

1 76. Respondent L M Caldwell Pharmacists- Pueblo Street and Respondent Yahyavi
2 failed to appropriately scrutinize patients' drug therapy with readily available tools such as
3 CURES⁶ reports and its own pharmacy records. Respondents did not have a process to validate
4 prescriptions. As a result, they repeatedly dispensed controlled substances early in certain
5 instances to patients who habitually engaged in doctor shopping and multiple pharmacy activity.
6 Questionable drug therapies were visible from Respondent L M Caldwell- Pueblo Street's own
7 records and showed the prescribing pattern of Dr. Diaz was repetitive and redundant with respect
8 to the same controlled substances prescribed repeatedly for the majority of his patients. His
9 prescribing habits included numerous large quantities of opiates in combination with minor
10 tranquilizers. Patients received on average three to four pain medications with one to two anti-
11 anxiety drugs. The patients included, but were not limited to GA, RB, CB, CC, JF, CG, GJ, IJ,
12 ML, KM, MM, SP, VS, MS, and RS. Four of these patients were on Suboxone/Subtex, used for
13 treating opiate addiction, prior to, during and/or after treatment by Dr. Diaz. A review of CURES
14 and their own records would have been a red flag for Respondents. For example:

15 a. Patient GA went to 4 prescribers, in Goleta and Santa Barbara, and 3 pharmacies in
16 Santa Barbara from January 1, 2009 to April 9, 2013. Patient GA had no anxiety history prior to
17 April 21, 2011 and prior to seeing Dr. Diaz. However, Dr. Diaz started him with a high dose of
18 Alprazolam 2 mg. Patient VA paid cash for his prescriptions when insurance did not cover the
19 cost. Review of CURES showed therapy duplication based on the number of opiates and
20 tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions dispensed at
21 Respondent LM Caldwell Pharmacist- Pueblo Street. Most pain medication was prescribed by
22 Dr. Diaz, despite him not being a pain specialist. He received numerous prescriptions for HC/AP
23 10/325 mg and Methadone prescribed by Dr. Diaz on or around the same time he had them
24 dispensed at different pharmacies. In the month of August 2010, for example, Patient VA
25 received 960 tablets of HC/AP 10/325 mg within 30 days and received 10,400 mg per day, well
26 above the recommended dose (of Acetaminophen) of 4,000 mg per day. In July of 2011, for

27 ⁶ Respondent Yahyavi advised the Board that he obtained access to CURES at the end of
28 2011.

1 example, Patient VA received 1,080 tablets of HC/AP 10/325 mg within 30 days. Patient VA
2 received 13,000 mg per day. In January of 2011, for example, Patient VA received a 30 day
3 supply of Methadone 10 mg from one pharmacy and then received another 30 day supply from
4 another pharmacy, LM Pharmacist- Pueblo Street, ten days later on, January 25, 2011;

5 b. Patient RB went to 3 prescribers in Santa Barbara and 4 pharmacies, in Ojai and
6 Santa Barbara from January 1, 2009 to April 9, 2013. He lived in OakView and traveled
7 approximately 30.33 miles to Santa Barbara to see prescriber Dr. Diaz. Respondent LM Caldwell-
8 Pueblo Street was approximately 33.17 miles from Patient RB's home and 2.88 miles from Dr.
9 Diaz's office. Patient RB paid cash for his prescriptions and paid over \$200.00 for Oxycodone
10 and Hydromorphone. Review of CURES showed therapy duplication based on the number of
11 opiates and tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions
12 dispensed at Respondent LM Caldwell Pharmacist- Pueblo Street. Most pain medication was
13 prescribed by Dr. Diaz, despite him not being a pain specialist. The following prescriptions
14 dispensed by LM Caldwell Pharmacists-Pueblo Street for Oxycodone were questionable:

15 Prescription Nos. 347843, 347918, and 338143 were written by Dentist Jeff Peppard;

16 c. Patient CB went to 4 prescribers in Santa Barbara and 11 pharmacies, in Ojai and
17 Santa Barbara, Port Hueneme, Sacramento and St. Louis Missouri from January 1, 2009 to April
18 9, 2013. He lived in Santa Barbara (although the exact address he listed could not be found
19 through mapquest) and paid cash for his prescriptions. Review of CURES showed therapy
20 duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr.
21 Diaz while having prescriptions dispensed at Respondent LM Caldwell Pharmacist- Pueblo
22 Street. Most pain and anxiety medication was prescribed by Dr. Diaz, despite him not being a
23 pain specialist. CB received multiple prescriptions for HC/AP 10/325 mg and Alprazolam @mg
24 on or around the same time by Dr. Diaz which he had dispensed at different pharmacies,
25 including for example: On March 26, 2010 Patient CB received HC/AP 10/325 #200 (25 day
26 supply) dispensed at Rite Aid #5782 (Prescription No. 676053) and on April 9, 2010 he received
27 HC/AP 10/325#240(30 day supply) dispensed at Respondent LM Caldwell Pharmacists-Pueblo
28 Street (Prescription No. 316460). The prescriptions were refilled again at Ride Aid on April 29,

1 2010, May 29, 2010, June 14, 2010, July 10, 2010 and at Respondent L M Caldwell- Pueblo
2 Street on May 24, 2010 and July 15, 2010. Patient CB received 440 tablets of HC/AP in 30 days,
3 5200 mg per day of Acetaminophen, well above the recommended 4,000 mg dose per day. In
4 addition, September 27, 2010, Respondent L M Caldwell Pharmacists- Pueblo Street received 2
5 different prescriptions for Oxycodone 30 mg form Dr. Diaz's office for Patient CB. After Dr.
6 Diaz was investigated, Patient CB did not get any prescriptions dispensed at L M Caldwell
7 Pharmacist-Pueblo Street nor did patient CB have any significant history of pain or anxiety drug
8 treatment.

9 d. Patient CC went to 22 prescribers and 13 pharmacies from January 1, 2009 to April 9,
10 2013. He went to prescribers in Bakersfield, Goleta, Isla Vista, Long Beach, Santa Barbara and
11 Santa Maria. He went to pharmacies in Goleta, Santa Barbara, Torrance and Wilmington. Prior
12 to and while going to Respondent L M Caldwell Pharmacist-Pueblo Street, Patient CC went to
13 numerous prescribers and pharmacies. He lived in Goleta (although the exact two addresses he
14 listed could not be found through mapquest) and paid cash for his prescriptions of HC/AP,
15 Carisoprodol, Oxycodone/AP and Hydromorphone. Review of CURES showed therapy
16 duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr.
17 Diaz while having prescriptions dispensed at Respondent LM Caldwell Pharmacist-Pueblo Street.
18 Most pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. For
19 example, Patient CC received 5,200 mg of Acetaminophen, an amount above the recommended
20 dose of Acetaminophen of 4,000 mg in October and November of 2011 through the following
21 prescriptions dispensed at Respondent L M Caldwell Pharmacists- Pueblo Street: Prescription
22 No. 334473 for AP/Oxycodone 10/325 mg #240 (30 day supply) on October 20, 2011,
23 Prescription No. 333957 for HC/AP 10/325 mg #240 (30 day supply) on October 31, 2011,
24 Prescription No. 335134 for AP/Oxycodone 10/325 mg #240 (30 day supply) on November 14,
25 2011, Prescription No. 333957 for AP/HC 10/325 mg #240 (30 day supply) on November 23,
26 2011. On August 2, 2010, Respondent L M Caldwell Pharmacist -Pueblo Street dispensed 2
27 prescriptions for Alprazolam 2 mg, Prescription No. 318318 and 319040 on the same day.
28 Patient CC continued to have most of his prescriptions dispensed at Respondent L M Caldwell

1 Pharmacist- Pueblo Street after Dr. Diaz. The number of pain medications and quantities were
2 reduced.

3 e. Patient JF went to 1 prescriber, Dr. Diaz in Santa Barbara, and 4 pharmacies, in Ojai,
4 Goleta, and Santa Barbara from January 1, 2009 to April 9, 2013. He lived Santa Barbara and
5 paid for his prescriptions through insurance. Review of CURES showed therapy duplication
6 based on the number of opiates and tranquilizers dispensed. Patient JF had no significant pain
7 history one year prior to January 20, 2010 and obtaining prescriptions from Dr. Diaz. However,
8 Dr. Diaz began his treatment with Oxycontin 80 mg, Morphine Sulfate 100 mg and Oxycodone
9 30 mg. Also, Patient JF did not have a history of anxiety nine months prior to obtaining
10 prescriptions from Dr. Diaz. However Dr. Diaz began treatment with Lorazepam 2 mg. Most
11 pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. JF was
12 prescribed the long acting opiates, Opana ER, Oxycontin, and MS Contin by Dr. Diaz at the
13 same time and were dispensed by Respondent L M Caldwell Pharmacist-Pueblo Street. These
14 long acting drugs are usually not prescribed together. Patient JF did not get any prescriptions
15 dispensed at Respondent LM Caldwell Pharmacist- Pueblo Street after Dr. Diaz;

16 f. Patient CG went to 10 prescribers and 5 pharmacies in Santa Barbara from January 1,
17 2009 to April 9, 2013. She went to prescribers in Lompoc, Santa Barbara, Carpinteria and
18 Sacramento. She lived in Carpinteria and traveled 10.63 miles to get to Dr. Diaz's Office in
19 Santa Barbara and Respondent L M Caldwell Pharmacist- Pueblo Street was located 13.63 miles
20 away from Patient CG's home. Patient CG paid for her prescriptions through insurance. Review
21 of CURES showed therapy duplication based on the number of opiates and tranquilizers
22 dispensed. Patient CG mostly went to Respondent L M Caldwell Pharmacist-Pueblo Street while
23 going to Dr. Diaz. Most pain medication was prescribed by Dr. Diaz, despite him not being a
24 pain specialist. Respondent L M Caldwell Pharmacist- Pueblo Street dispensed prescriptions in
25 November 2009 through February 2010 above the 4,000 mg recommended dose of
26 Acetaminophen. Respondent L M Caldwell Pharmacist- Pueblo Street also dispensed numerous
27 prescriptions for Suboxone, used for treatment of opioid addiction, from Dr. Diaz while
28 prescribing other narcotics. Respondent L M Caldwell Pharmacist- Pueblo Street also dispensed

1 Prescription Nos. 312135, 312136, 333177, 333178, 335385, 33586 for the long action opiates,
2 Opana ER and Oxycontin. Patient CG continued to get most pain and anxiety prescriptions
3 dispensed at Respondent L M Caldwell Pharmacist-Pueblo Street after Dr. Diaz, but the quantity
4 and therapy duplication was reduced by other prescribers. Respondent L M Caldwell Pharmacist-
5 Pueblo Street dispensed Prescription Nos. 319209, 319172, 319173 which were telephoned by the
6 prescriber's office but did not note the name of the agent of the prescriber nor the pharmacist who
7 transcribed it;

8 g. Respondent L M Caldwell Pharmacist-Pueblo Street dispensed Prescription Nos.
9 337054, 337055 and 337056 with no prescriber signature and date to Patient IJ on January 3,
10 2012;

11 h. Patient ML went to 2 prescribers and 3 pharmacies, in Ojai, Goleta, and Santa
12 Barbara from January 1, 2009 to April 9, 2013. She lived in Santa Barbara (same address as
13 Patient IJ and Patient GJ) and paid cash for her prescriptions when not covered by insurance.
14 Review of CURES showed therapy duplication based on the number of opiates and tranquilizers
15 dispensed. While going to Respondent L M Caldwell Pharmacist-Pueblo Street, she mainly went
16 to Dr. Diaz. Patient ML received various HC/AP drugs prescribed by Dr. Diaz on or around the
17 same time which she had dispensed at multiple pharmacies, including Respondent L M Caldwell
18 Pharmacist- Pueblo Street. ML Received 5,166 mg per day of Acetaminophen, for example in
19 September of 2009, an amount over the recommended dose of Acetaminophen of 4,000 mg per
20 day. She received 7,100 mg per day of Acetaminophen in November, 2010 from Respondent L
21 M Caldwell Pharmacist- Pueblo Street and January 2011. Patient ML only had one pain
22 prescription dispensed at Respondent L M Caldwell Pharmacist-Pueblo Street after Dr. Diaz. A
23 review of Patient ML's Profile revealed she received mostly pain medication from Dr. Diaz, who
24 was not a pain specialist;

25 i. Patient KM went to 4 prescribers in Santa Barbara and Lompoc and 13 pharmacies
26 from January 1, 2009 to April 9, 2013. She went to pharmacies in Lompoc, Santa Barbara, Santa
27 Maria, Orcutt and San Luis Obispo. She lived in Lompoc (same address as Patient MM) and
28 traveled 55.81 miles to Dr. Diaz's office and lived 53.28 miles from Respondent L M Caldwell

1 Pharmacist- Pueblo Street. Patient KM paid cash for her prescriptions and paid over \$350.00 for
2 Oxycodone and Hydromorphone. Review of CURES showed therapy duplication based on the
3 number of opiates and tranquilizers dispensed. She received only pain and anxiety medication
4 from Dr. Diaz, despite him not being a pain specialist. On January 12, 2011, Patient KM
5 received Oxycodone #180 and January 19, 2011 received Oxycodone #60. On February 11, 2011
6 he received #180 and on February 15, 2011, he received #60. KM should have had enough
7 tablets and the unusual dosage changes should have been questioned by Respondent L M
8 Caldwell Pharmacist- Pueblo Street. Patient KM did not get any pain or anxiety prescriptions
9 dispensed at Respondent L M Caldwell Pharmacist- Pueblo Street after Dr. Diaz;

10 j. Patient MM went to 17 prescribers and 20 pharmacies from January 1, 2009 to April
11 8, 2013. She went to prescribers in Santa Barbara, Lompoc, Lodi, Encinitas, San Luis Obispo,
12 Santa Maria, Solvang and Stanford and went to pharmacies in Lompoc, Santa Barbara, Santa
13 Maria, Orcutt, Buellton, San Luis Obispo and Pismo Beach. Prior to going to Respondent L M
14 Caldwell –Pueblo Street, she went to multiple pharmacies and prescribers. She lived in Lompoc
15 (same address as Patient KM) and traveled 55.81 miles to Dr. Diaz’s office and lived 53.28 miles
16 from Respondent L M Caldwell Pharmacist-Pueblo Street. Patient KM paid cash when early
17 refills were obtained and/or when medication was not covered by insurance. Patient KM paid
18 \$327.00 for Oxycodone and \$1,585.00 for Oxycontin. Review of CURES showed therapy
19 duplication based on the number of opiates and tranquilizers dispensed. She received only pain
20 and anxiety medication from Dr. Diaz, despite him not being a pain specialist. Patient MM
21 received multiple Oxycodone 30 mg prescriptions on or around the same time from Dr. Diaz
22 which she had dispensed at multiple pharmacies. She also received multiple Oxycontin 80 mg
23 prescriptions on or around the same time from Dr. Diaz which she had dispensed at multiple
24 pharmacies, including at Respondent L M Caldwell Pharmacist-Pueblo Street. Patient MM also
25 received Suboxone, prior to and while going to Respondent L M Caldwell Pharmacist-Pueblo
26 Street. Patient MM did not get any pain or anxiety prescriptions dispensed at LM Caldwell
27 Pharmacist- Pueblo Street after Dr. Diaz. Patient MM received only pain and anxiety medication
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1 from Dr. Diaz, despite him not being a pain specialist. Patient MM paid \$1,585.80 cash for
2 Oxycontin 60 mg on July 4, 2010;

3 k. Patient SP went to 6 prescribers in Santa Barbara and 7 pharmacies from January 1,
4 2009 to April 9, 2013. She went to pharmacies in Lompoc, Santa Barbara, and Goleta. She lived
5 in Santa Barbara and paid for her medication through insurance. Review of CURES showed
6 therapy duplication based on the number of opiates and tranquilizers dispensed. Patient SP
7 received mostly pain and anxiety medication from Dr. Diaz, despite him not being a pain
8 specialist. Respondent L M Caldwell Pharmacist-Pueblo Street dispensed Prescription No. 33143
9 for Oxycodone IR (1 Tablet, twice daily #60) for a 30 day supply on July 18, 2011 and then again
10 on July 28, 2011 (Prescription No. 33176, 1-3 tablets every 4-6 hours #240.) Patient SP also
11 received therapy duplication in the form of Diazepam and Alprazolam and HC/AP and
12 HC/Ibuprofen from Respondent L M Caldwell Pharmacist- Pueblo Street. Patient SP continued
13 to get one pain medication dispensed at Respondent L M Caldwell Pharmacist- Pueblo Street
14 after Dr. Diaz. The number of pain drugs prescribed by other prescribers was reduced. Patient
15 SP was placed on Suboxone and did not have significant pain or anxiety after Dr. Diaz;

16 l. Patient VS went to 3 prescribers and 6 pharmacies from January 1, 2009 to April 8,
17 2013. She went to prescribers in Santa Barbara, Lompoc and Goleta and went to pharmacies in
18 Lompoc, Santa Barbara, and Santa Maria. She lived in Lompoc (same address as Patient MM)
19 and traveled 55.81 miles to Dr. Diaz's office and lived 53.28 miles from Respondent L M
20 Caldwell Pharmacist- Pueblo Street. Patient VS paid cash for her prescriptions when insurance
21 did not cover the cost of medication. Patient VS paid over \$250.00 for Oxycodone and \$220.00
22 Hydromorphone. Review of CURES showed therapy duplication based on the number of opiates
23 and tranquilizers dispensed. Patient VS received mostly pain and anxiety medication from Dr.
24 Diaz, despite him not being a pain specialist. Respondent L M Caldwell Pharmacist- Pueblo
25 Street dispensed Prescription Nos. 33225, 033221, 33220, 33223 and 33222 with a written date
26 that was not in the prescriber's handwriting. Patient VS received Hydromorphone 4 mg and 8 mg
27 at or around the same time prescribed by Dr. Diaz which he had dispensed sometimes at the same
28 pharmacy, including Respondent L M Caldwell Pharmacist- Pueblo Street. Patient VS did not get

1 any pain or anxiety medication dispensed at LM Caldwell Pharmacist- Pueblo Street after
2 September 14, 2011 and did not have any significant pain or anxiety history after Dr. Diaz was
3 investigated.

4 m. Patient MS went to 7 prescribers and 12 pharmacies from January 1, 2009 to April 9,
5 2013. She went to prescribers in Santa Barbara, Solvang, and Goleta and to pharmacies in
6 Lompoc, Santa Barbara, Oxnard, Santa Ynez Santa Maria and Goleta. She lived in Santa Barbara
7 and paid cash for her medication. She paid approximately \$350.00 for Hydromorphone, \$103 for
8 Methadone, \$130.00 for Alprazolam, \$218.00 for HC/AP, and \$200.00 for Oxycodone. Review
9 of CURES showed therapy duplication based on the number of opiates and tranquilizers
10 dispensed. Patient MS went to multiple pharmacies and mainly went to Dr. Diaz. Patient MS
11 received mostly pain and anxiety medication from Dr. Diaz, despite him not being a pain
12 specialist. Patient MS received multiple prescriptions for AC/AP 10/325 mg from Dr. Diaz
13 which she dispensed at multiple pharmacies. She received 600-840 tablets of HC/AP within 30
14 days and received 7,800 mg per day to 9,750 mg per day of Acetaminophen. The practice of
15 Patient MS receiving multiple prescriptions dispensed at multiple pharmacies began in March of
16 2010 and continued monthly until November of 2011. Patient MS received multiple prescriptions
17 for Alprazolam 2 mg from Dr. Diaz which she dispensed at multiple pharmacies. MS received
18 240-360 tablets of Alprazolam within 30 days. Patient MS had a couple of pain prescriptions
19 dispensed at Respondent L M Caldwell Pharmacist-Pueblo Street after Dr. Diaz and the quantities
20 and therapy duplications prescribed by other prescribers were reduced;

21 n. Patient RS went to 2 prescribers in Santa Barbara and 6 pharmacies in Santa Barbara
22 and Goleta from January 1, 2009 to April 9, 2013. She lived in Santa Barbara and paid cash for
23 her medication. She paid approximately \$225.00 for Hydromorphone, \$175.00 for HC/AP, and
24 \$107 for Alprazolam. Review of CURES showed therapy duplication based on the number of
25 opiates and tranquilizers dispensed. Patient MS went to multiple pharmacies and mainly went to
26 Dr. Diaz. Patient MS received mostly pain and anxiety medication from Dr. Diaz, despite him
27 not being a pain specialist. Patient RS had no significant pain or anxiety history prior to going to
28 Dr. Diaz. However, Dr. Diaz began by prescribing him Methadone 10 mg, Hydromorphone 8 mg,

1 HC/AP 10/325 mg and Alprazolam 2 mg. Patient RS received multiple prescriptions for HC/AP
2 10/325 mg from Dr. Diaz which he dispensed at multiple pharmacies. Patient RS received 480
3 tablets of HC/AP within 30 days and received 5,200 mg per day of Acetaminophen. The practice
4 of Patient RS getting multiple prescriptions dispensed at multiple pharmacies began in August of
5 2011 and continued monthly until December of 2011. Patient RS did not get any pain or anxiety
6 prescriptions dispensed at Respondent LM Caldwell Pharmacist -- Pueblo Street after Dr. Diaz.
7 Respondent L M Caldwell Pharmacist- Pueblo Street dispensed Prescription No. 336005 for
8 Buprenorphine, used for treatment of narcotic addiction on December 1, 2011, prescribed by Dr.
9 Diaz.

10 77. L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi did not know the
11 diagnosis for patients GA, RB, CB, CC, JF, CG, GJ, IJ, ML, KM, MM, SP, VS, MS, RS, and
12 knew that Dr. Diaz was a family practitioner and not a pain management physician. Also, L M
13 Caldwell Pharmacist-Pueblo Street and Respondent Caldwell failed to maintain records or files
14 on drug therapy for these patients, and failed to check data in CURES.

15 78. When reviewing the records for patients GA, RB, CB, CC, JF, CG, GJ, IJ, ML, KM,
16 MM, SP, VS, MS, and RS, it was noted that eight out of these fifteen patients lived outside Dr.
17 Diaz's trading area and five out of nine lived outside of Respondent LM Caldwell Pharmacist-
18 Pueblo Street normal trading area. The range of distance travelled for the selected patients was
19 between 6.97 miles for the shortest to 111.97 for the longest. The average distance traveled by
20 the patient was 35.26 miles and the total distance these patients travelled to obtain controlled
21 substances was excessive. Five of the fifteen patient home addresses were not recognized by
22 Mapquest. In addition seven of the fifteen patients had the same address. Eight of the fifteen
23 patients reviewed lived outside of Dr. Diaz's normal trading area and five of fifteen lived outside
24 of L M Caldwell Pharmacist-Pueblo Street normal trading area.

25 79. Most of the patients paid cash, including when the medication was not covered
26 by their insurance or to get early refills. Some patients had insurance/Medicaid, however, were
27 willing to pay a large sum of cash for controlled substances which were not covered by the plans,
28 including those on Medicaid.

1 80. There was excessive furnishing of controlled substances prescribed by Dr. Diaz. The
2 dispensing ratio of prescriptions by Dr. Diaz by L M Caldwell Pharmacist -Pueblo Street and
3 Respondent Yahyavi was greatly unbalanced when compared to other neighboring pharmacies,
4 including the following three pharmacies: Federal Drugs PHY37078 (located 1.83 miles from L
5 M Caldwell Pharmacist-Pueblo Street), Rite-Aid #5785 PHY 42255 (located 1.72 miles from L M
6 Caldwell Pharmacist-Pueblo Street), and CVS#9392 PHY 494473 (located 1.46 miles from L M
7 Caldwell Pharmacist-Pueblo Street). Respondent L M Caldwell Pharmacist-Pueblo Street filled
8 tens of thousands more controlled substances prescribed by Dr. Diaz when compared to
9 neighboring pharmacies for the time period specified of January 1, 2011 through December 5,
10 2012. The CURES data for the L M Caldwell Pharmacist- Pueblo Street and three surrounding
11 pharmacies, for example, was as follows:

Pharmacy	Total controlled substances dispensed between 1/1/2011-12/5/2012	Total Dr. Diaz's RX from 1/1/2011-12/5/2012	Total quantity for Dr. Diaz's RX from 1/1/2011-12/5/2012	% of total controlled substance RX dispensed for Dr. Diaz
Respondent LM Caldwell Pharmacist – Pueblo Street	11,215	1,418	215,186	12.64%
Federal Drugs PHY 37078 (1.92 miles from LM Caldwell)	18, 282	0	0	0%
Rite-Aid #5785 PHY 42255 (.065 miles from LM Caldwell Pharmacist)	3,584	0	0	0%
CVS # 9392 PHY 49473 (.41 miles from LM Caldwell)	13,365	44	6,599	.33%

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1 **Pattern of Early Refills and Duplicate Medications**

2 81. Between January 1, 2010 and December 7, 2012, LM Caldwell-Pueblo Street
3 engaged in a pattern of early refills, including for Patients GA, RB, CB, CC, JF, CG, GJ, IJ, ML,
4 KM, MM, SP, VS, MS and RS, including, for example, 22 days early for Patient RB (Prescription
5 Nos. 335933 & 336232), 24 days early for Patient CB (Prescription Nos. 328602 & 328602) 25
6 days for Patient CC (Prescription Nos. 325881 & 326067), 16 days early for Patient CG
7 (Prescription Nos. 312824 & 312824), 25 days early for Patient GJ (Prescription Nos. 329632 &
8 329632), 18 days early for Patient IJ (Prescription Nos. 328627 & 328627) 27 days early for
9 Patient ML (Prescription Nos. 317889 & 31789), 29 days early for Patient MM (Prescription Nos.
10 326892 & 326705), and 16 days early for Patient MS (Prescription Nos. 331092 & 331728).

11 **Patient AM**

12 82. On December 10, 2013, the Board received a medical malpractice payment report,
13 Santa Barbara Superior Court, Case No. 1414079, from American Casualty Co. of Reading PA
14 for Respondent Yahyavi, without admission of negligence or liability. On February 3, 2014, the
15 Board received a report of settlement judgment or arbitration award, Case No. 1414079, from
16 Chicago Insurance Company for Respondent Yahyavi, without the admission of guilt.
17 Prescribing of narcotic medication which led to death was alleged in the civil suit. The Board
18 confirmed that both settlement reports were regarding Patient AM and the insurance companies
19 split the costs of settlement. Patient AM, presented prescriptions from a medical doctor which
20 Respondent Yahyavi dispensed. On November 25, 2011, Patient AM died from acute
21 complications from narcotic abuse. At the time of his death, Patient AM had multiple controlled
22 substances in his system.

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1 83. A review of Respondent L M Caldwell Pharmacists- Pueblo Street's profile for
 2 Patient AM revealed that Patient AM received the following controlled substances at Respondent
 3 LM Caldwell Pharmacists-Pueblo Street:

RX Date	RX #	Drug	Prescriber
8/23/2010	320263	Hydromorphone 8 mg 2 tablets every 6 hours as needed for pain #240	Dr. Diaz
	230234	Oxycodone 30 mg 2 tablet every 6 hours as needed for pain. #240	
9/20/2010	321036	Hydromorphone 8 mg 2 tablets every 4-6 hours as needed for pain #240	Dr. Diaz
		Oxycodone 30 mg 2 tablet every 4-6 hours as needed for pain. #240	
10/14/2010	322230	Oxycodone 30 mg 2 tablet every 2-4 hours #260	Dr. Diaz
	322231	Hydromorphone 8 mg 2 tablets every 2-4 hours #260	
	322232	Methadone 10 mg 2 pills every 12 hours #120	
11/11/2010	323197	Hydromorphone 8 mg 2 tablets every 4-6 hours #260	Dr. Diaz
	323198	Oxycodone 30 mg 2 tablet every 4-6 hours #260	

22 84. A review of Respondent L M Caldwell Pharmacists- Pueblo Street's profile for
 23 Patient AM and CURES records also revealed that Patient AM saw 4 prescribers and went to 8
 24 pharmacies from January 1, 2009 to April 8, 2013. Patient AM saw prescribers in Santa Barbara,
 25 Solvang, and Shell Beach. Patient AM received only pain medication from Dr. Diaz, despite him
 26 not being a pain specialist. Patient AM traveled over 70 miles from home in Solvang to obtain
 27 the prescriptions from Dr. Diaz and then to Respondent LM Caldwell Pharmacists-Pueblo Street
 28 to have the prescriptions dispensed. Patient AM paid cash for his medication.

1 85. Respondent LM Caldwell Pharmacists-Pueblo Street and Respondent Yahyavi
2 dispensed 9 prescriptions for AM. However, if they would have checked CURES data, they
3 would have been able to determine there were unusual prescribing patterns for Dr. Diaz and that
4 Patient AM was going to multiple pharmacies. Patient AM, for example, went to 2 separate
5 pharmacies on the same day to get Oxycodone and Hydromorphone. Since Respondent Yahyavi
6 knew Dr. Diaz as the "Candy Man," he should have questioned the legitimacy of his
7 prescriptions.

8 86. From January 1, 2010 to January 1, 2014, Respondent LM Caldwell Pharmacists-
9 Pueblo Street and Respondent Yahyavi, failed to exercise best professional judgment while
10 dispensing controlled substance prescriptions for Patient AM prescribed by Dr. Diaz. There were
11 significant, objective factors of irregularity in AM's prescriptions, including repetitive prescribing
12 patterns for highly abused controlled substances, the location of prescriber's practice in relation to
13 the location of AM's residence, and the patient's payment methods. Respondent Yahyavi also
14 failed to appropriately scrutinize patients' drug therapy with readily available tools such as
15 CURES reports and its own pharmacy records. The result of this negligence was the dispensing
16 of controlled substances for AM who habitually engaged in doctor shopping and multiple
17 pharmacy activity. Respondent Yahyavi should have questioned the legitimacy of the
18 prescriptions it and Respondent L M Caldwell Pharmacists-Pueblo Street dispensed to Patient
19 AM.

20 **Patient ES**

21 87. On May 4, 2015, the Board received a settlement payment report, Santa Barbara
22 Superior Court, Case No. 1439529, from Chicago Insurance Company for Respondent Yahyavi,
23 without admission of negligence or liability. On May 7, 2015, the Board received a report of
24 settlement judgment or arbitration award, Case No. 1439529, from American Casualty Co. of
25 Reading for Respondent Yahyavi, without the admission of guilt. The Board confirmed that both
26 settlement reports were regarding Patient ES and the insurance companies split the costs of
27 settlement. Patient ES presented prescriptions from a medical doctor, Dr. Diaz, which
28 Respondent Yahyavi dispensed. The civil complaint alleged that ES became addicted to

1 prescription medications and ultimately died resulting from negligent prescribing by Dr. Diaz and
2 negligent dispensing by Respondent L M Caldwell Pharmacists-Pueblo Street and Respondent
3 Yahyavi. The complaint further alleged that the pharmacists failed to conduct an appropriate
4 drug utilization review of patient prescription data in dispensing ES's prescriptions. The coroner
5 determined ES's death was an "accidental death due to multiple drug ingestion."

6 88. A review of the PAR for Patient ES revealed that all but two of ES's prescriptions
7 filled in 2009 and 2010 were written by Dr. Diaz. The PAR for ES contained 32 entries for
8 controlled substance prescriptions filled in 2009 and 37 entries for controlled prescriptions filled
9 in 2010. Starting in July 15, 2009, ES received all but three of her prescriptions from LM
10 Caldwell Pharmacists- Pueblo Street. No documentation was found supporting verification of
11 ES's prescriptions or regarding communication with Dr. Diaz regarding ES's prescriptions.
12 Further, the irregularities found in the prescriptions remained unresolved even if Dr. Diaz would
13 have been consulted.

14 89. The majority of the prescriptions ES received in 2010 were controlled substances. Of
15 70 prescriptions ES received in 2010, 55 prescriptions (78.57%) were written for controlled
16 substances and 15 were written for non-controlled substances. These prescriptions included pain
17 medications prescribed by Dr. Diaz, despite him not being a pain specialist. Of the 15 non-
18 controlled substance prescriptions, 9 prescriptions were written for Carisoprodol 350 mg federally
19 classified as a controlled substance on January 11, 2012 due to its potential for abuse and
20 diversion. Accordingly, as of 2012, 64 out of 70 prescriptions were considered controlled
21 substances (91.4%). ES received 11 different medications from LM Caldwell Pharmacists-
22 Pueblo Street in 2010. Indications for the medications ES received included attention deficit
23 disorder, muscle spasms, anxiety, diarrhea, pain, diabetes, asthma, and seizures or migraine
24 headaches.

25 90. ES receive very large daily dose of narcotic pain relievers. The following table
26 includes prescriptions ES received in June 2010:

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Drug	Quantity	Days Supply	Mg per day	Morphine Equivalent Daily Dose ⁷
Hydromorphone 8 mg	180	30	48 mg	192 mg
Hydrocodone/acetaminophen 10/325mg	180	25	72 mg (hydrocodone)	72 mg
Methadone 10 mg	90	30	30 mg	240 mg
Hydrocodone/acetaminophen 7.5/750 mg	150	30	37.5 mg (hydrocodone)	37.5 mg
				Total 541.5 mg

91. ES received excessive quantities and doses of narcotic pain relievers. For example, ES received 600 tablets of narcotic pain relievers in June 2010, an average of over 19 tablets per day. If ES took these four medications concurrently and as directed, she would have received a daily dose of Morphine equivalent to approximately 541 mg. ES received potentially duplicative therapy including two strengths of the same medication, hydrocodone/acetaminophen 7.5/750 mg and hydrocodone/acetaminophen 10/325 mg. Between June 21, 2010 and August 23, 2010, ES received prescriptions for two different strengths of hydrocodone/acetaminophen combinations. Taken together, these two medications contained between 5,258 mg and 5,892 mg per day - more than the recommended maximum daily dose of acetaminophen, 4 g (4,000 mg).⁸ A patient receiving more than 4 g of acetaminophen per day represents a significant irregularity which would warrant a pharmacist's conference with the prescriber to attempt to resolve the dosing issue. The combination of a benzodiazepine (clonazepam) and methadone along with three other narcotic pain relievers (hydrocodone/acetaminophen 10/325 mg, hydrocodone acetaminophen

⁷ The Morphine Equivalent Dose of a medication can be considered the dose of Morphine which would achieve the same effect as a dose of the given medication.

⁸ The maximum daily dose of acetaminophen in 2010 was 4 g (4,000 mg) per day. In 2014, the recommended maximum daily dose was decreased to 3, 250 mg per day but doses up to 4, 000 may still be used under provider supervision.

1 7.5/750 mg, and hydromorphone) was a significant irregularity in ES's profile. ES received
2 prescriptions for methadone and clonazepam despite a potentially serious drug interaction
3 between these two drugs in that clonazepam may increase the respiratory depressant effect of
4 methadone. Dr. Diaz's prescriptions for ES, which included high dose narcotics and medications
5 to treat anxiety and attention-deficit disorder, were inconsistent with his self-reported areas of
6 practice on the public Breeze of general practice, geriatric medicine and pathology.

7 92. Also, because Respondent Yahyavi knew Dr. Diaz as the "Candy Man," as stated
8 above, he should have questioned the legitimacy of his prescriptions.

9 93. Respondent LM Caldwell Pharmacists-Pueblo Street and Respondent Yahyavi failed
10 to exercise best professional judgment while dispensing controlled substance prescriptions for
11 Patient ES prescribed by Dr. Diaz. There were significant, objective factors of irregularity in ES's
12 prescriptions from Dr. Diaz that should have indicated to LM Caldwell Pharmacists-Pueblo Street
13 and Respondent Yahyavi that these prescriptions were not issued in the usual course of
14 professional treatment. These factors include: ES's dispensing history for 2010 containing 91.4%
15 controlled substances or Carisopodol, the receipt of more than 4 mg of acetaminophen per day,
16 the combination of a benzodiazepine (clonazepam) and methadone along with three other
17 narcotic pain relievers (hydrocodone/acetaminophen 10/325 mg, hydrocodone acetaminophen
18 7.5/750 mg, and hydromorphone), and the repetitive prescribing patterns for highly abused
19 controlled substances. Respondent Yahyavi should have questioned the legitimacy of the
20 prescriptions it and Respondent L M Caldwell Pharmacists-Pueblo Street dispensed to Patient
21 ES.

22 **Conviction and Medical Board Disciplinary Action**

23 94. On April 29, 2011, the Board received an arrest report from the California
24 Department of Justice for Pharmacy Technician DLM who had been arrested on allegations that
25 he stole Oxycontin from his employer Respondent L M Caldwell Pharmacist-State Street and sold
26 the drugs to an undercover detective. In May of 2011, Pharmacy Technician DLM, following a
27 plea, was convicted of the sale of a controlled substance Oxycontin under Health and Safety Code
28 section 11352, subdivision (a).

1 95. On January 5, 2012, the Board received notification that Dr. Diaz was allegedly
2 linked to a string of deaths involving prescriptions drugs and had been arrested for allegedly
3 prescribing an excessive amount of painkillers to his patients. On May 13, 2014, the California
4 Medical Board revoked Dr. Diaz's license as a general practitioner and his specialty in Geriatrics
5 and Pathology for gross negligence in the care and treatment of a patient, prescribing excessive
6 narcotic medications to patients, and failing to maintain adequate and accurate records.

7 **Board Inspections and Audits**

8 96. On July 13, 2011, January 1, 2013, and January 15, 2013, the Board inspected
9 Respondent L M Caldwell Pharmacist-State Street. The Board also conducted audits of
10 Respondent L M Caldwell Pharmacist-State Street from 2009 to January 2013.

11 97. On January 16, 2013, the Board inspected Respondent L M Caldwell Pharmacist-
12 Pueblo Street. During the inspection, Respondent Yahyavi admitted to the inspector that he
13 knew Dr. Diaz as the "Candy Man." The Board also conducted audits of Respondent L M
14 Caldwell Pharmacist-Pueblo Street from 2009 to January 2013.

15 98. On April 8, 2013, the Board issued a written Notice of Noncompliance to Respondent
16 L M Caldwell Pharmacist-State Street and Respondent Caldwell. The Board also issued a written
17 Notice of Noncompliance to Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent
18 Yahyani.

19 99. On July 31, 2013, the Board issued a written Notice of Noncompliance to Respondent
20 L M Caldwell Pharmacists-Pueblo Street and Respondent Yahyavi.

21 100. On August 7, 2013, the Board issued another written Notice of Noncompliance to
22 Respondent L M Caldwell Pharmacists-State Street and Respondent Caldwell.

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1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacy)**

3 **(Against Respondent L M Caldwell Pharmacist -State Street)**

4 101. Respondent L M Caldwell Pharmacist-State Street is subject to discipline under
5 section 4301, subsection (o) of the Code, and/or California Code of Regulations, title 16, section
6 1714, subsection (b), for failure to maintain its facilities, space, fixtures, and equipment so that
7 drugs are safely and properly prepared, maintained, secured and distributed. The circumstances
8 are that between November 15, 2009 to July 13, 2011, Respondent L M Caldwell Pharmacist-
9 State Street could not account for the loss of 5,360 tablets of Hydromorphone 8 mg. Between
10 August 6, 2011 to January 15, 2013, Respondent L M Caldwell Pharmacist-State Street could not
11 account for the loss of 8,800 tablets of Hydromorphone 8 mg and the loss of 605 tablets of
12 Oxycodone 30 mg. Complainant refers to, and by this reference, incorporates the allegations set
13 forth above in paragraphs 44 through 46, as though set forth fully.

14 **SECOND CAUSE FOR DISCIPLINE**

15 **(Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacist)**

16 **(Against Respondent Caldwell)**

17 102. Respondent Caldwell is subject to discipline under section 4301, subdivision (o), of
18 the Code, and California Code of Regulations, title 16, section 1714, subdivision (d), for failure to
19 maintain the security of the prescription department, including provisions for effective control
20 against theft or diversion of dangerous drugs and devices, and records for such drugs and devices
21 and to ensure that possession of a key to the pharmacy where dangerous drugs and controlled
22 substances are stored is restricted to pharmacists. The circumstances are that between November
23 15, 2009 to July 13, 2011, Respondent Caldwell could not account for the loss of 5,360 tablets of
24 Hydromorphone 8 mg. Between August 6, 2011 to January 15, 2013, Respondent Caldwell could
25 not account for the loss of 8,800 tablets of Hydromorphone 8 mg and the loss of 605 tablets of
26 Oxycodone 30 mg. Complainant refers to, and by this reference, incorporates the allegations set
27 forth above in paragraphs 44 through 46, as though set forth fully.

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1 THIRD CAUSE FOR DISCIPLINE

2 (Failure to Maintain Records of Acquisition and Disposition of Dangerous Drugs)
3 (Against Respondent L M Caldwell Pharmacist- State Street, Respondent L M Caldwell
4 Pharmacist- Pueblo Street, Respondent Caldwell, and Respondent Yahyavi)

5 103. Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell
6 Pharmacist-Pueblo Street, Respondent Caldwell and Respondent Yahyavi, are each and severally
7 subject to disciplinary action under section 4081, subdivision (a), and section 4105, subdivision
8 (a) of the Code, for failure to maintain all records of sale, acquisition or disposition of dangerous
9 drugs at all times open to inspection and preserved for at least three years from the date of
10 making. The circumstances are as follows:

11 a. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could
12 not account for the records of acquisition and disposition and the current inventory. Between
13 November 15, 2009 and July 13, 2011, Respondent L M Caldwell Pharmacist- State Street and
14 Respondent Caldwell could not account for an inventory overage (disposition greater than
15 acquisition) of 55,370 tablets of HC/AP 10/325 mg and 165 tablets of Oxycodone SR 80 mg.
16 Between August 6, 2011 and January 15, 2013, Respondent L M Caldwell Pharmacist-State
17 Street and Respondent Caldwell could not account for an inventory overage of 78,746 tablets of
18 HC/AP 10/325 mg. Complainant refers to, and by this reference, incorporates the allegations set
19 forth above in paragraphs 44 through 45, as though set forth fully.

20 b. Between January 5, 2010 and January 15, 2013, Respondent L M Caldwell
21 Pharmacist-State Street and Respondent Caldwell could not account for prescription hardcopies
22 for Prescriptions Nos. 793824, 793825, 793826, 789177, 789188, 793189, 793190, 805552,
23 782075, 792283, 793432, 793184, 791387, 797610, 787609, 790594, 790595, 790597, 795658,
24 804361, 792346, 793090, 795652, 776675, 773787, 779441, 780927, 790980, 792044, 792920,
25 792935 and 792928. Complainant refers to, and by this reference, incorporates the allegations set
26 forth above in paragraphs 46, as though set forth fully.

27 ///

1 c. Between December 18, 2010 and December 17, 2012, Respondent L M Caldwell
2 Pharmacist-Pueblo Street and Respondent Yahyavi could not account for an inventory overage of
3 53,811 tablets of HC/AP 10/325 mg. Complainant refers to, and by this reference, incorporates
4 the allegations set forth above in paragraph 70, as though set forth fully.

5 c. On January 16, 2013, LM Caldwell Pharmacist-Pueblo Street and Respondent
6 Yahyavi were unable to provide the original prescription documents for RX # 327435, 334405, ,
7 317892, 317893, 317894, 330297, 323526, 324203, 325803, 325881, 312027, 316180, 315861,
8 322717, 322718, 319209, 322715, 330610, 333178, 334336, 318220, 331648, 322460, 332461,
9 326892, 327949, 332102, and 336005. Complainant refers to, and by this reference, incorporates
10 the allegations set forth above in paragraph 71, as though set forth fully.

11 **FOURTH CAUSE FOR DISCIPLINE**

12 **(Failure to Provide Drug Sales and Purchase Records After Furnishing Dangerous Drugs)**
13 **(Against Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell**
14 **Pharmacist- Pueblo Street, Respondent Caldwell and Respondent Yahyavi)**

15 104. Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell
16 Pharmacist-Pueblo Street, Respondent Caldwell and Respondent Yahyavi, are each and severally
17 subject to disciplinary action under section 4059, subdivision (b), of the Code, for furnishing a
18 dangerous drug or dangerous device to each other without sales and purchase records that
19 correctly give the date, names and addresses of the supplier and buyer, the drug or device and the
20 quantity. The circumstances are as follows:

21 a. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell
22 Pharmacist-State Street and Respondent Caldwell sold HC/AP 10/325 mg to Respondent
23 Caldwell Pharmacist- Pueblo Street without adequate sales records. Complainant refers to, and
24 by this reference, incorporates the allegations set forth above in paragraph 49, as though set forth
25 fully.

26 ///

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28

1 b. Between July 23, 2010 and December 28, 2012, L M Caldwell Pharmacist-Pueblo
2 Street and Respondent Yahyavi purchased HC/AP 10/325 mg from Caldwell Pharmacist-State
3 Street without adequate purchase records. Complainant refers to, and by this reference,
4 incorporates the allegations set forth above in paragraph 72, as though set forth fully.

5 **FIFTH CAUSE FOR DISCIPLINE**

6 **(Unprofessional Conduct: Failure to Exercise Corresponding Responsibility)**
7 **(Against Respondent L M Caldwell Pharmacist- State Street, Respondent L M Caldwell**
8 **Pharmacist- Pueblo Street, Respondent Caldwell and Respondent Yahyavi)**

9 105. Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell
10 Pharmacist- Pueblo Street, Respondent Caldwell and Respondent Yahyavi are each and severally
11 subject to disciplinary action under section 4301, subdivisions (d) and (j), of the Code, Health and
12 Safety code section 11153, subdivision (a), and California Code of Regulations, title 16, section
13 1761, subdivisions (a) and (b), for excessive furnishing of controlled substances with an
14 established history of a high potential for abuse despite multiple cues of irregularity and
15 uncertainty related to patient and prescriber factors, and in failing to comply with their
16 corresponding responsibility to ensure that controlled substances are dispensed for a legitimate
17 medical purpose:

18 a. Specifically, between January 1, 2011 and December 5, 2012, Respondent L M
19 Caldwell Pharmacist- State Street, and Respondent Caldwell dispensed 1,492 controlled
20 substance prescriptions written by Dr. Julio Diaz with disregard to the following factors: distance
21 from the pharmacy to Dr. Diaz's office, distance from the pharmacy to each patient's home,
22 percentage of cash patients specific to listed prescribers, pattern of patients willing to pay cash for
23 highly expensive prescriptions, and same or similar prescribing patterns for individual patients
24 from alleged pain specialists. Respondent L M Caldwell Pharmacist-State Street, and Respondent
25 Caldwell failed to appropriately scrutinize patients' drug therapy with readily available tools such
26 as CURES reports and its own pharmacy records, including to Patients VA, BA, KB, CD, LD,
27 TF, JH, MM, AM, SM, SS, JS, NS, VS and CW. From January 1, 2010 to January 1, 2013, LM
28 Caldwell Pharmacist-State Street and Respondent Caldwell failed to exercise their corresponding

1 responsibility with regard to Patient JJ. Complainant refers to, and by this reference, incorporates
2 the allegations set forth above in paragraphs 50 through 69 as though set forth fully.

3 b. Specifically, between January 1, 2011 and December 7, 2012, Respondent L M
4 Caldwell Pharmacist- Pueblo Street, and Respondent Yahyavi dispensed 1,418 controlled
5 substance prescriptions written by Dr. Julio Diaz with disregard to the following factors: distance
6 from the pharmacy to Dr. Diaz's office, distance from the pharmacy to each patient's home,
7 percentage of cash patients specific to listed prescribers, pattern of patients willing to pay cash for
8 highly expensive prescriptions, and same or similar prescribing patterns for individual patients
9 from alleged pain specialists. Respondent L M Caldwell Pharmacist-Pueblo Street, and
10 Respondent Yahyavi failed to appropriately scrutinize patients' drug therapy with readily
11 available tools such as CURES reports and its own pharmacy records, including to Patients GA,
12 RB, CB, CC, JF, CG, IJ, ML, KM, MM, SP, VS, MS and RS. From January 1, 2010 to January
13 1, 2014, LM Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi also failed to exercise
14 their corresponding responsibility with regard to Patient AM. From January 11, 2010 to October
15 8, 2010, LM Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi failed to exercise their
16 corresponding responsibility with regard to Patient ES. Complainant refers to, and by this
17 reference, incorporates the allegations set forth above in paragraphs 75 through 95, as though set
18 forth fully.

19 **SIXTH CAUSE FOR DISCIPLINE**

20 **(Unprofessional Conduct: Dispensing Prescriptions Which**
21 **Contains Significant Error, Omission, Irregularity, Uncertainty, Ambiguity or Alteration)**
22 **(Against Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell)**

23 106. Respondent L M Caldwell Pharmacist- State Street, and Respondent Caldwell are
24 each and severally subject to disciplinary action under section 4301, subdivision (o), of the Code,
25 and California Code of Regulations section 1761, subdivisions (a) and (b), for dispensing a
26 prescription which contained a significant error, omission, irregularity, uncertainty, ambiguity, or
27 alteration, for failing to contact the prescriber to obtain information to validate the prescription,
28 and/or for dispensing a controlled substance knowing or having the objective reason to know that

1 the prescription was not issued for a legitimate purpose, even after conferring with the prescriber.

2 The circumstances are as follows:

3 a. On March 22, 2011, Respondent L M Caldwell Pharmacist-State Street and
4 Respondent Caldwell dispensed Prescription No. 784841 for Morphine Sulfate 10 mg/ml solution
5 that was written with no quantity on the prescription with the quantity box for "151 & over"
6 marked. Respondent L M Caldwell Pharmacist- State Street and Respondent Caldwell
7 dispensed 360 mls of Morphine Sulfate solutions with no documentation on the prescription
8 indicating that the prescribing physician, Dr. Diaz, was contacted to clarify the quantity.
9 Complainant refers to, and by this reference, incorporates the allegations set forth above in
10 paragraph 57, subparagraph (d), as though set forth fully.

11 b. On May 20, 2011, Respondent L M Caldwell Pharmacist-State Street and Respondent
12 Caldwell dispensed Prescription No. 784839 for Fentanyl 100 mcg/hour with directions to apply
13 every 48 hours. The manufacturer's direction was to change the patch every 72 hours.
14 Complainant refers to, and by this reference, incorporates the allegations set forth above in
15 paragraph 57, subparagraph (e), as though set forth fully.

16 **SEVENTH CAUSE FOR DISCIPLINE**

17 **(Exceeding the Day Supply for Controlled Substance Refills)**

18 **(Against Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell)**

19 107. Respondent L M Caldwell Pharmacist-State Street, and Respondent Caldwell are
20 each and severally subject to disciplinary action under Health and Safety Code section 11200,
21 subdivision (b) for refilling a prescription for Schedule II or IV substance more than five times
22 and/or in an amount, for all refills of that prescription taken together, exceeding a 120-day supply.

23 The circumstances are as follows:

24 a. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell
25 dispensed Prescription No. 782251 for Alprazolam, a Schedule IV controlled substance, on
26 March 25, 2011 for a 30 day supply. They then refilled Prescription No. 782251 five times on
27 April 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011, for a total of
28 five (5) refills for a total of a 150-day supply. Complainant refers to, and by this reference,

1 incorporates the allegations set forth above in paragraph 58, subparagraph (a), as though set forth
2 fully.

3 b. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell
4 dispensed Prescription No. 782250 for Diazepam, a Schedule IV controlled substance, on March
5 25, 2011 for a 30 day supply. They then refilled Prescription No. 782250 on April 22, 2011, May
6 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011, for a total of five (5) refills for a
7 total of a 150-day supply. Complainant refers to, and by this reference, incorporates the
8 allegations set forth above in paragraph 58, subparagraph (b), as though set forth fully.

9 **EIGHTH CAUSE FOR DISCIPLINE**

10 **(Unprofessional Conduct: Variation from Prescription)**

11 **(Against Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi)**

12 108. Respondent L M Caldwell Pharmacist-Pueblo Street, and Respondent Yahyavi are
13 each and severally subject to disciplinary action under section 4301, subdivision (o), of the Code,
14 and California Code of Regulations section 1716, when they deviated from the requirements of a
15 prescription without the prior consent of the prescriber. Specifically, between January 1, 2010
16 and January 15, 2013, they dispensed the following prescriptions incorrectly:

17 (1) Prescription No. 321310, was for Oxycodone 30 mg 1-2 every 6 hour as needed for
18 pain. Respondents dispensed it as 1 tablet four times daily as needed for pain;

19 (2) Prescription No. 321312, was for Xanax mg 1-2 times daily for panic. Respondents
20 dispensed it as 1 tablet four times daily;

21 (3) Prescription No. 325038, was for 30 mg 1-2 HC/AP 7.5/750 mg. Prescriber wrote 1
22 tablet every 6 hours as needed for pain and Respondents dispensed it as 1 tablet every 4-6 hours
23 as needed for pain;

24 (4) Prescription No. 331728, was for Dilaudid 8 mg, 1 every 6 hours #120. Respondents
25 dispensed Hydromorphone 8 mg, 1-2 tablets every 6 hours;

26 (5) Prescription No. 332908, was for Methadone 10 mg 7 tablets every 12 hours #400.
27 Respondents dispensed it as 6 tablets every 12 hours;

28

1 (6) Prescription No. 335645, was for Oxycodone IR 30 mg 1 tablet every 4-6 hour.
2 Respondents dispensed Oxycodone IR 30 mg 1 tablet every 6 hours.

3 Complainant refers to, and by this reference, incorporates the allegations set forth above in
4 paragraph 73, subdivisions (a) through (f) as though set forth fully.

5 **NINTH CAUSE FOR DISCIPLINE**

6 **(Unprofessional Conduct: Dispensing Balance of**
7 **Schedule II Prescriptions Beyond 72 hours)**

8 **(Against Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi)**

9 109. Respondent L M Caldwell Pharmacist-Pueblo Street, and Respondent Yahyavi are
10 each and severally liable to disciplinary action under section 4301, subdivision (o), of the Code,
11 and California Code of Regulations section 1745, subdivision (d), as it related to Code of Federal
12 Regulations 1306.13, subdivision (a) as follows:

13 a. Review of prescriptions, from January 1, 2010 to January 15, 2013, revealed that
14 Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi partially filled
15 prescriptions for controlled substances listed in Schedule II and then dispensed the balance of the
16 prescription after the 72 hour period allowed for dispensing the balance of prescriptions.
17 Specifically between January 1, 2010 to January 15, 2013, Respondents dispensed Prescription
18 Nos. 329771, 331396, 332230, and 33265, then dispensed the balance of the prescriptions after 72
19 hours. Complainant refers to, and by this reference, incorporates the allegations set forth above
20 in paragraph 74 as though set forth fully.

21 **OTHER MATTERS**

22 110. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number
23 PHY 30911 issued to Peter Caldwell to do business as L M Caldwell Pharmacist, L M Caldwell
24 Pharmacist shall be prohibited from serving as a manager, administrator, owner, member, officer,
25 director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 30911
26 is placed on probation or until Pharmacy Permit Number PHY 30911 is reinstated if it is revoked.

27 ///

1 111. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number
2 PHY 530911 issued to Peter Caldwell to do business as L M Caldwell Pharmacist while Peter
3 Caldwell has been an officer and owner and had knowledge of or knowingly participated in any
4 conduct for which the licensee was disciplined, Peter Caldwell shall be prohibited from serving as
5 a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for
6 five years if Pharmacy Permit Number PHY 30911 is placed on probation or until Pharmacy
7 Permit Number PHY 30911 is reinstated if it is revoked.

8 112. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number
9 PHY 30912 issued to L M Caldwell Pharmacist dba L M Caldwell Pharmacists, LM Caldwell
10 Pharmacist shall be prohibited from serving as a manager, administrator, owner, member, officer,
11 director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 30912
12 is placed on probation or until Pharmacy Permit Number PHY 30912 is reinstated if it is revoked.

13 113. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number
14 PHY 530912 issued to Peter Caldwell to do business as L M Caldwell Pharmacist while Peter
15 Caldwell has been an officer and owner and had knowledge of or knowingly participated in any
16 conduct for which the licensee was disciplined, Peter Caldwell shall be prohibited from serving as
17 a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for
18 five years if Pharmacy Permit Number PHY 30912 is placed on probation or until Pharmacy
19 Permit Number PHY 30912 is reinstated if it is revoked.

20 **DISCIPLINE CONSIDERATIONS**

21 114. To determine the degree of discipline, if any, to be imposed on Respondent L M
22 Caldwell Pharmacists-Pueblo Street, Complainant alleges that on or about February 27, 2007, in a
23 prior action, the Board of Pharmacy issued Citation Number CI 2006-32134 against Respondent
24 L M Caldwell Pharmacist-Pueblo Street for violating California Code of Regulations, title 16,
25 section 1716. A copy of the citation is attached as Exhibit A. That Citation is now final and is
26 incorporated as if fully set forth. Complainant further alleges that on or about November 14,
27 2008, in a prior action, the Board of Pharmacy issued Citation Number CI 2007-35415 against
28 Respondent L M Caldwell Pharmacists-Pueblo Street for violating California Code of

1 Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit B. That Citation
2 is now final and is incorporated as if fully set forth.

3 115. To determine the degree of discipline, if any, to be imposed on Respondent Yahyavi,
4 Complainant alleges that on or about February 27, 2007, in a prior action, the Board of Pharmacy
5 issued Citation Number CI 2006-32988 against Respondent Yahyavi and ordered him to pay fines
6 in the amount of \$ 250.00 for violating California Code of Regulations, title 16, section 1716. A
7 copy of the citation is attached as Exhibit C. That Citation is now final and is incorporated as if
8 fully set forth. Complainant further alleges that on or about November 14, 2008, in a prior action,
9 the Board of Pharmacy issued Citation Number CI 2008-37974 against Respondent Yahyavi and
10 ordered him to pay fines in the amount of \$750.00 for violating California Code of Regulations,
11 title 16, section 1716. A copy of the citation is attached as Exhibit D. That Citation is now final
12 and is incorporated as if fully set forth.

13 116. To determine the degree of discipline, if any, to be imposed on Respondent L M.
14 Caldwell Pharmacists- State Street, Complainant alleges that on or about July 23, 2013, in a prior
15 action, the Board of Pharmacy issued Citation Number CI 2011 49544 against Respondent L M.
16 Caldwell Pharmacists- State Street for violating California Code of Regulations, title 16, section
17 1716 and section 1711, subdivisions (d) and (e). A copy of the citation is attached as Exhibit E.
18 That Citation is now final and is incorporated as if fully set forth herein.

19 117. To determine the degree of discipline, if any, to be imposed on Respondent Caldwell,
20 Complainant alleges that on or about July 23, 2013, in a prior action, the Board of Pharmacy
21 issued Citation Number CI 2013 57599 against Respondent Caldwell for violating California
22 Code of Regulations, title 16, section 1716 and section 1711, subdivisions (d) and (e). A copy of
23 the citation is attached as Exhibit F. That Citation is now final and is incorporated as if fully set
24 forth herein. Respondent Caldwell, Complainant alleges that on or about February 29, 2012, in a
25 prior action, the Board of Pharmacy issued Citation Number CI 2010 48187 against Respondent
26 Caldwell for violating California Code of Regulations, title 16, section 1732.5 and Business and
27 Professions Code 4231, subdivision (d) and 4301, subdivision (g). A copy of the citation is
28 attached as Exhibit G. That Citation is now final and is incorporated as if fully set forth herein.

1 PRAYER

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

4 1. Revoking or suspending Pharmacy Permit Number PHY 30911, issued to Peter
5 Caldwell to do business as L M Caldwell Pharmacist;

6 2. Revoking or suspending Pharmacy Permit Number PHY 30912, issued to L M
7 Caldwell Pharmacist to do business as L M Caldwell Pharmacist;

8 3. Revoking or suspending Pharmacist License Number 25356, issued to Peter Craig
9 Caldwell;

10 4. Revoking or suspending Pharmacist License Number 30041, issued to Abdul
11 Yahyavi;

12 5. Prohibiting LM Caldwell Pharmacist (PHY 30911) from serving as a manager,
13 administrator, owner, member, officer, director, associate, or partner of a licensee for five years if
14 Pharmacy Permit Number PHY 30911 is placed on probation or until Pharmacy Permit Number
15 PHY 30911 is reinstated if Pharmacy Permit Number 50434 issued to L M Caldwell Pharmacist
16 is revoked;

17 6. Prohibiting Peter Caldwell from serving as a manager, administrator, owner, member,
18 officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number
19 PHY 30911 is placed on probation or until Pharmacy Permit Number PHY 30911 is reinstated if
20 Pharmacy Permit Number 30911 issued to L M Caldwell Pharmacist is revoked;

21 7. Prohibiting LM Caldwell Pharmacist (PHY 30912) from serving as a manager,
22 administrator, owner, member, officer, director, associate, or partner of a licensee for five years if
23 Pharmacy Permit Number PHY 30912 is placed on probation or until Pharmacy Permit Number
24 PHY 30912 is reinstated if Pharmacy Permit Number 30912 issued to L M Caldwell Pharmacist
25 is revoked;

26 ///

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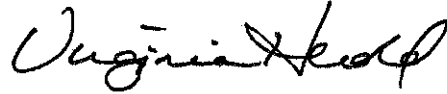
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1 8. Prohibiting Peter Caldwell from serving as a manager, administrator, owner, member,
2 officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number
3 PHY 30912 is placed on probation or until Pharmacy Permit Number PHY 30912 is reinstated if
4 Pharmacy Permit Number 30912 issued to L M Caldwell Pharmacist is revoked;

5 9. Ordering L M Caldwell Pharmacist (PHY 30911), L M Caldwell Pharmacist (PHY
6 30912), Peter Craig Caldwell, and Abdul Yahyavi to pay the Board of Pharmacy the reasonable
7 costs of the investigation and enforcement of this case, pursuant to Business and Professions
8 Code section 125.3;

9 10. Taking such other and further action as deemed necessary and proper.

10 DATED: 6/27/16



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

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8 . BEFORE THE
BOARD OF PHARMACY
9 DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

10
11 In the Matter of the First Amended Accusation
Against:

Case No. 4867

12
13 **PETER CRAIG CALDWELL** doing
business as **L M CALDWELL**
14 **PHARMACIST**
1509 State St.
15 Santa Barbara, CA 93101
Pharmacy Permit No. PHY 30911

FIRST AMENDED ACCUSATION

16
17 **PETER CRAIG CALDWELL** doing
business as **L M CALDWELL**
18 **PHARMACIST**
235 West Pueblo St.
19 Santa Barbara, CA 93105
Pharmacy Permit No. PHY 30912

20
21 **PETER CRAIG CALDWELL**
1509 State St.
22 Santa Barbara, CA 93101
Pharmacist License No. RPH 25356

23
24 **ABDUL YAHYAVI**
1624 La Coronilla Drive.
25 Santa Barbara, CA 93109
Pharmacist License No. RPH 30041

26 Respondent.

1 Complainant alleges:

2 **PARTIES**

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

6 2. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit
7 Number PHY 30911 to Peter Caldwell to do business as L M Caldwell Pharmacist located at
8 1509 State Street, Santa Barbara, CA 93101 (Respondent L M Caldwell Pharmacist-State Street).
9 The Pharmacy Permit was in full force and effect at all times relevant to the charges brought
10 herein and will expire on December 1, 2015, unless renewed. Peter C. Caldwell has been the
11 individual licensed owner of Respondent State Street Pharmacy since December 13, 1984. Peter
12 C. Caldwell has been the Pharmacist-In-Charge of Respondent State Street Pharmacy since
13 December 13, 1984.

14 3. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit
15 Number PHY 30912 to Peter Caldwell to do business as L M Caldwell Pharmacist located at 235
16 West Pueblo Street, Santa Barbara, CA 93105 (Respondent L M Caldwell Pharmacist- Pueblo
17 Street). The Pharmacy Permit was in full force and effect at all times relevant to the charges
18 brought herein and will expire on December 1, 2015, unless renewed. Abdul Yahyavi was the
19 Pharmacist-In-Charge of Respondent Pueblo Street Pharmacy from December 1, 1984 to October
20 1, 2014. Catherine Young Nance became the Pharmacist in Charge on October 1, 2014.

21 4. On or about January 9, 1968, the Board of Pharmacy issued Pharmacist Number
22 25356 to Peter Craig Caldwell (Respondent Caldwell). The Pharmacist License was in full force
23 and effect at all times relevant to the charges brought herein and will expire on May 31, 2016,
24 unless renewed.

25 5. On or about December 10, 1975, the Board of Pharmacy issued Pharmacist Number
26 30041 to Abdul Yahyavi (Respondent Yahyavi). The Pharmacist License was in full force and
27 effect at all times relevant to the charges brought herein and will expire on June 30, 2014, unless
28 renewed.

1 JURISDICTION

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

5 7. Section 118, subdivision (b), of the Code provides that the suspension/expiration/
6 surrender/cancellation of a license shall not deprive the Board/Registrar/Director of jurisdiction to
7 proceed with a disciplinary action during the period within which the license may be renewed,
8 restored, reissued or reinstated.

9 8. Section 4300 of the Code states:

10 (a) Every license issued may be suspended or revoked.

11 (b) The board shall discipline the holder of any license issued by the board, whose
12 default has been entered or whose case has been heard by the board and found guilty,
by any of the following methods:

13 (1) Suspending judgment.

14 (2) Placing him or her upon probation.

15 (3) Suspending his or her right to practice for a period not exceeding on
16 year.

17 (4) Revoking his or her license.

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

20 ...

21 (e) The proceedings under this article shall be conducted in accordance with Chapter
22 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code,
23 and the board shall have all the powers granted therein. The action shall be final,
except that the propriety of the action is subject to review by the superior court
pursuant to Section 1094.5 of the Code of Civil Procedure."

24 9. Section 4300.1 of the Code states:

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

1 STATUTORY AUTHORITY

2 10. Section 4301 of the Code states:

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

7 (a) Gross immorality.

8 (b) Incompetence.

9 (c) Gross negligence.

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

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

19 ...

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

22 ...

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

28 ...

11. Section 4022 of the Code states

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use
in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without
prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to
sale by or on the order of a _____," "Rx only," or words of similar import, the
blank to be filled in with the designation of the practitioner licensed to use or order
use of the device.

///

1 (c) Any other drug or device that by federal or state law can be lawfully dispensed
2 only on prescription or furnished pursuant to Section 4006.

3 12. Section 4059 of the Code states:

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

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

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

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

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

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

24 13. Section 4081 of the Code states:

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

36 (b) The owner, officer, and partner of any pharmacy, wholesaler, or veterinary
37 food-animal drug retailer shall be jointly responsible, with the pharmacist-in-charge
38 or representative-in-charge, for maintaining the records and inventory described in
39 this section.

40 (c) The pharmacist-in-charge or representative-in-charge shall not be criminally
41 responsible for acts of the owner, officer, partner, or employee that violate this
42 section and of which the pharmacist-in-charge or representative-in-charge had no
43 knowledge, or in which he or she did not knowingly participate.

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14. Section 4105 of the Code states:

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

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

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

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

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

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

(f) When requested by an authorized officer of the law or by an authorized representative of the board, the owner, corporate officer, or manager of an entity licensed by the board shall provide the board with the requested records within three business days of the time the request was made. The entity may request in writing an extension of this timeframe for a period not to exceed 14 calendar days from the date the records were requested. A request for an extension of time is subject to the approval of the board. An extension shall be deemed approved if the board fails to deny the extension request within two business days of the time the extension request was made directly to the board.

15. Section 4333 of the Code states, in pertinent part, that all prescriptions filled by a pharmacy and all other records required by Section 4081 shall be maintained on the premises and available for inspection by authorized officers of the law for a period of at least three years. In cases where the pharmacy discontinues business, these records shall be maintained in a board-licensed facility for at least three years.

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

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

(b) Any person who knowingly violates this section shall be punished by imprisonment in the state prison or in the county jail not exceeding one year, or by a fine not exceeding twenty thousand dollars (\$20,000), or by both a fine and imprisonment.

(c) No provision of the amendments to this section enacted during the second year of the 1981-82 Regular Session shall be construed as expanding the scope of practice of a pharmacist.

17. Health and Safety Code section 11200 states in pertinent part:

(a) No person shall dispense or refill a controlled substance prescription more than six months after the date thereof.

(b) No prescription for a Schedule III or IV substance may be refilled more than five times and in an amount, for all refills of that prescription taken together, exceeding a 120-day supply.

(c) No prescription for a Schedule II substance may be refilled.

STATE REGULATORY AUTHORITY

18. California Code of Regulations, title 16, section 1711, states:

(a) Each pharmacy shall establish or participate in an established quality assurance program which documents and assesses medication errors to determine cause and an appropriate response as part of a mission to improve the quality of pharmacy service and prevent errors.

...

(d) Each pharmacy shall use the findings of its quality assurance program to develop pharmacy systems and workflow processes designed to prevent medication errors. An investigation of each medication error shall commence as soon as is reasonably possible, but no later than 2 business days from the date the medication error is discovered. All medication errors discovered shall be subject to a quality assurance review.

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1 (e) The primary purpose of the quality assurance review shall be to advance error
2 prevention by analyzing, individually and collectively, investigative and other
3 pertinent data collected in response to a medication error to assess the cause and any
4 contributing factors such as system or process failures. A record of the quality
5 assurance review shall be immediately retrievable in the pharmacy. The record shall
6 contain at least the following:

- 7 1. the date, location, and participants in the quality assurance review;
- 8 2. the pertinent data and other information relating to the medication error(s)
9 reviewed and documentation of any patient contact required by subdivision (c);
- 10 3. the findings and determinations generated by the quality assurance review; and,
- 11 4. recommend changes to pharmacy policy, procedure, systems, or processes, if any.
12 The pharmacy shall inform pharmacy personnel of changes to pharmacy policy,
13 procedure, systems, or processes made as a result of recommendations generated in
14 the quality assurance program.

15 ...

16 19. California Code of Regulations, title 16, section 1714, states:

17 ...

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

22 ...

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

28 ...

29 20. California Code of Regulations, title 16, section 1716, states:

30 Pharmacists shall not deviate from the requirements of a prescription except upon the
31 prior consent of the prescriber or to select the drug product in accordance with
32 Section 4073 of the Business and Professions Code. Nothing in this regulation is
33 intended to prohibit a pharmacist from exercising commonly-accepted pharmaceutical
34 practice in the compounding or dispensing of a prescription.

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21. California Code of Regulations, title 16, section 1745, states:

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(b) A "partially filled" prescription is a prescription from which only a portion of the amount for which the prescription is written is filled at any one time; provided that regardless of how many times the prescription is partially filled, the total amount dispensed shall not exceed that written on the face of the prescription.

...

(d) A pharmacist may partially fill a prescription for a controlled substance listed in Schedule II, if the pharmacist is unable to supply the full quantity ordered by the prescriber. The pharmacist shall make a notation of the quantity supplied on the face of the written prescription. The remaining portion of the prescription may be filled within 72 hours of the first partial filling. If the remaining portion is not filled within the 72-hour period, the pharmacist shall notify the prescriber. The pharmacist may not supply the drug after 72 hour period has expired without a new prescription.

22. California Code of Regulations, title 16, section 1761, states:

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

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

FEDERAL REGULATORY AUTHORITY

23. 21 Code of Federal Regulations, part 1306, section 13.06.13 states, in pertinent part:

(a) The partial filling of a prescription for a controlled substance listed in Schedule II is permissible if the pharmacist is unable to supply the full quantity called for in a written or emergency oral prescription and he makes a notation of the quantity supplied on the face of the written prescription, written record of the emergency oral prescription, or in the electronic prescription record. The remaining portion of the prescription may be filled within 72 hours of the first partial filling; however, if the remaining portion is not or cannot be filled within the 72-hour period, the pharmacist shall notify the prescribing individual practitioner. No further quantity may be supplied beyond 72 hours without a new prescription.

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1 **COSTS**

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

6 **DRUGS**

7 25. Acetaminophen is a Schedule III controlled substance as designated in Health and
8 Safety Code section 11056(e)(2) and is categorized as a dangerous drug pursuant to section 4022
9 of the Code.

10 26. Alprazolam, sold under the brand name Xanax, is a Schedule IV controlled substance
11 under Health and Safety Code section 11057 and a dangerous drug under Business and
12 Professions Code Section 4022. Alprazolam is used to treat anxiety disorders and panic disorder.
13 Alprazolam is in a class of medications called benzodiazepines. Alprazolam comes as a tablet, An
14 extended-release tablet, and an orally disintegrating tablet. The tablet and orally disintegrating
15 table usually are taken two to four times a day. The extended-release tablet is taken once daily,
16 usually in the morning. Alprazolam may heighten the euphoric effect resulting from the use of an
17 Oxycodone.

18 27. Diazepam, a generic for the brand name Valium, a Benzodiazepam derivative, is a
19 Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(9)
20 and is categorized as a dangerous drug pursuant to section 4022 of the Code.

21 28. Dilaudid is a trade name for Hydromorphone, an Opium derivative, which is
22 classified as a Schedule II Controlled Substance pursuant to Health and Safety Code section
23 11055, subdivision (b)(1), and is a dangerous drug within the meaning of Business and
24 Professions Code section 4022.

25 29. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code
26 section 11055(c)(8) and is a dangerous drug pursuant to Business and Professions Code section
27 4022.

1 30. Hydrocodone is in Schedule II of the Controlled Substances Act. Lortab, Norco and
2 Vicodin, brand/trade names of preparations containing hydrocodone in combination with other
3 non-narcotic medicinal ingredients, are in Schedule III pursuant to Health and safety Code section
4 11056(e)(4), and are categorized as dangerous drugs pursuant to section 4022.

5 31. Morphine Sulfate, the narcotic substance is a preparation of Morphine, the principal
6 alkaloid of Opium. It is classified as a Schedule II controlled substance as designated by Health
7 and Safety Code section 11055, subdivisions (b)(1)(L) and (b)(2). It is categorized as a
8 dangerous drug pursuant to Business and Professions Code section 4022.

9 32. Norco is the brand name for the combination narcotic, Hydrocodone and
10 Acetaminophen, and is a Schedule III¹ controlled substance pursuant to Health and Safety Code
11 section 11056(e) and is categorized as a dangerous drug pursuant to Business and Professions
12 Code section 4022

13 33. Opana ER is an opioid and schedule II controlled substance.

14 34. Opiates are types of narcotic drugs that act as depressants in the central nervous
15 system. They come from opium, which can be produced naturally from poppy plants or derived
16 from semi-synthetic alkaloids. Some of the most common opiates include morphine, codeine,
17 heroin, hydrocodone and oxycodone. Opiates are pain killers and can produce drowsiness, nausea,
18 constipation and slow breathing.

19 35. Oxycontin, a brand name formulation of oxycodone hydrochloride and/or Oxycodone
20 SR, is an opioid agonist and a Schedule II controlled substance with an abuse liability similar to
21 morphine. OxyContin is for use in opioid tolerant patients only. It is a Schedule II controlled
22 substance pursuant to Health and Safety Code section 11055, subdivision (b)(1), and a dangerous
23 drug pursuant to Business and Professions Code section 4022.

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27 ¹ Effective October 6, 2014, the Drug Enforcement Administration rescheduled
28 Hydrocodone combination products from schedule III to schedule II of the Controlled Substances
Act. (See 21 CFR Part 1308 § 1308.12; 21 U.S.C. 812 (c))

1 36. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code
2 section 11055, subdivision (b)(1)(M) and is a dangerous drug pursuant to Business and
3 Professions Code section 4022. Oxycodone is a narcotic analgesic used for moderate to severe
4 pain and it has a high potential for abuse.

5 37. Suboxone, the brand name of buprenorphine and naloxone, is classified as a Schedule
6 IV controlled substance pursuant to Health and Safety Code section 11058(d), and is a dangerous
7 drug pursuant to Business and Professions Code section 4022. It is used for the treatment of
8 opiate addiction.

9 38. Tranquilizers are central nervous system depressant drugs classified as sedative-
10 hypnotics and are classified into two main categories: minor tranquilizers (anxiolytic, or anti-
11 anxiety agents) and major tranquilizers (neuroleptics) drugs used to treat severe mental illnesses.
12 Minor tranquilizers may include Valium (diazepam), Librium/Novopoxide (chlordiazepoxide),
13 Halcion (triazolam), ProSom (estazolam), Xanax and Ativan.

14 FACTS

15 RESPONDENTS

16 39. Respondent L M Caldwell Pharmacist-State Street and Respondent L M Caldwell
17 Pharmacist-Pueblo Street (collectively Respondents L M Caldwell Pharmacists) are pharmacies
18 operating in the Santa Barbara area.

19 40. Respondent Caldwell is the Pharmacist in Charge at Respondent L M Caldwell
20 Pharmacist-State Street, and Respondent Yahyani was the Pharmacist in Charge at Respondent L
21 M Caldwell Pharmacist- Pueblo Street up to October 1, 2014.

22 41. Pharmacy Technician DLM² was employed at Respondent Caldwell Pharmacist-State
23 Street in 2011.

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27 ² Names are not being used to protect identities but individuals will be identified during
28 the course of discovery.

1 **LM CALDWELL PHARMACIST-STATE STREET AND RESPONDENT**

2 **CALDWELL**

3 **Records of Acquisition, Disposition and Storage of Drugs**

4 42. Drugs acquired by Respondents L M Caldwell Pharmacist were stored at Respondent
5 L M Caldwell Pharmacists-State Street. Drugs were sent to Respondent L M Caldwell
6 Pharmacist-Pueblo Street as needed. Drug recordkeeping included a transfer document which
7 showed the bottles sent to Respondent L M Caldwell Pharmacist-Pueblo Street. Also, the records
8 for Respondent L M Caldwell Pharmacist-Pueblo Street were located at Respondent L M
9 Caldwell Pharmacist-State Street.

10 43. Between November 15, 2009 and July 13, 2011, Respondent L M Caldwell
11 Pharmacist-State Street and Respondent Caldwell could not account for an inventory overage
12 (disposition greater than acquisition) of 55,370 tablets of Hydrocodone/Acetaminophen (HC/AP)
13 10/325 mg and 165 tablets of Oxycodone SR 80 mg. Between August 6, 2011 and January 15,
14 2013, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not
15 account for an inventory overage of 78,746 tablets of HC/AP 10/325 mg.

16 44. Between January 5, 2010 and January 15, 2013, Respondent L M Caldwell
17 Pharmacist -State Street and Respondent Caldwell could not account for prescription hardcopies
18 for Prescriptions Nos. 793824, 793825, 793826, 789177, 789188, 793189, 793190, 805552,
19 782075, 792283, 793432, 793184, 791387, 797610, 787609, 790594, 790595, 790597, 795658,
20 804361, 792346, 793090, 795652, 776675, 773787, 779441, 780927, 790980, 792044, 792920,
21 792935 and 792928.

22 **Operational Standards and Security**

23 45. Respondent Caldwell was responsible for the security and record keeping at
24 Respondents L M Caldwell Pharmacists. Between November 15, 2009 to July 13, 2011,
25 Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account
26 for the loss of 5,360 tablets of Hydromorphone 8 mg. Between August 6, 2011 to January 15,
27 2013, Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not
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1 account for the loss of 8,800 tablets of Hydromorphone 8 mg and for the loss of 605 tablets of
2 Oxycodone 30 mg.

3 46. Respondents L M Caldwell Pharmacists and Respondent Caldwell failed to maintain
4 an effective control of the security of the prescription department against theft or loss of
5 controlled substances/ dangerous drugs.

6 **Furnishing and Purchasing of Dangerous Drugs or Devices Without Adequate**
7 **Sales and Purchase Records**

8 47. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell
9 Pharmacist-State Street and Respondent Caldwell sold HC/AP 10/325 mg to Respondent L M
10 Caldwell Pharmacist- Pueblo Street without adequate sales records.

11 **Prescriptions Dispensed by L M Caldwell Pharmacist- State Street and**
12 **Respondent Caldwell**

13 48. Between January 1, 2011 and December 5, 2012, L M Caldwell Pharmacist-State
14 Street and Respondent Caldwell, dispensed a total of 11,817 controlled substance prescriptions of
15 which 1,492 were prescriptions written by Dr. Julio Gabriel Diaz, a family practice prescriber.
16 The prescriptions were dispensed without regard to the following factors:

17 (1) Pattern of patients willing to drive long distance to obtain controlled substance
18 prescriptions from Dr. Diaz and to fill the prescriptions at L M Caldwell Pharmacists and other
19 pharmacies;

20 (2) Percentage of cash patients specific to listed prescribers and pattern of patients
21 willing to pay cash for highly expensive prescriptions when insurance did not cover;

22 (3) Same or similar prescribing patterns for multiple patients, including at least three
23 opiates and one to two tranquilizers;

24 (4) Irregular pattern of early refills/ patient returning too frequently.

25 49. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell failed
26 in their corresponding responsibility to appropriately scrutinize patients' drug therapy with readily
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1 available tools such as CURES³ reports and its own pharmacy records. Respondents did not
2 have a process to validate prescriptions. As a result, they repeatedly dispensed controlled
3 substances early in certain instances to patients who habitually engaged in doctor shopping and
4 multiple pharmacy activity. Questionable drug therapies were visible from Respondent L M
5 Caldwell-State Street's own records and showed the prescribing pattern of Dr. Diaz was repetitive
6 and redundant with respect to the same controlled substances prescribed repeatedly for the
7 majority of his patients. His prescribing habits included numerous large quantities of opiates in
8 combination with minor tranquilizers. Patients received on average three to four pain
9 medications with one to two anti-anxiety drugs. The patients included, but were not limited to,
10 VA, BA, KB, CD, LD, TF, JH, MM, AM, SM, SS, JS, NS, VS, and CW. A review of CURES
11 and their own records would have been a red flag for Respondents. For example:

12 a. Patient VA went to 4 prescribers and 18 pharmacies from January 1, 2009 to April 8,
13 2013, including in Santa Maria, Arleta, Santa Barbara and Ventura. He lived in Oxnard and
14 traveled approximately 37.34 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-
15 State Street was approximately 39.67 miles from Patient VA's home and 1.85 miles from Dr.
16 Diaz's office. Patient VA paid cash for his prescriptions. Review of CURES showed therapy
17 duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr.
18 Diaz while having prescriptions dispensed at LM Caldwell Pharmacist- State Street. Most pain
19 medication was prescribed by Dr. Diaz, despite him not being a pain specialist. He received
20 numerous prescriptions for HC/AP 10/325 mg and Methadone prescribed by Dr. Diaz on or
21 around the same time he had them dispensed at different pharmacies. In the month of August
22 2010, for example, Patient VA received 960 tablets of HC/AP 10/325 mg within 30 days. He
23 received 10,400 mg per day, well above the recommended dose of (Acetaminophen) per day of

24 ³ CURES is an acronym for "California Utilization Review and Evaluation System." It
25 contains over 100 million entries of controlled substance drugs that were dispensed in California.
26 Pharmacists and prescribers can register with the Department of Justice to obtain access to the
27 CURES data through the California Prescription Drug Monitoring Program (PDMP). Patient
28 Activity Reports (PARs) are provided and reflect all controlled substances dispensed to an
individual. CURES herein refers to CURES in general and PARs. Pharmacies are required to
report to the California Department of Justice every schedule II, II and IV drug prescription under
Health and Safety Code section 1165, subdivision (d).

1 4,000 mg per day. In July of 2011, for example, Patient VA received 1,080 tablets of HC/AP
2 10/325 mg within 30 days. Patient VA received 13,000 mg per day. In January of 2011, for
3 example, Patient VA received a 30 day supply of Methadone 10 mg from one pharmacy and then
4 received another 30 day supply from another pharmacy, LM Pharmacist-State Street, ten days
5 later on, January 25, 2011;

6 b. Patient BA only saw one prescriber, Dr. Diaz, and went to 12 pharmacies from
7 January 1, 2009 to April 8, 2013. He lived in Ventura and traveled approximately 31.53 miles to
8 Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-State Street was approximately 33.86
9 miles from Patient BA's home and 1.85 miles from Dr. Diaz's office. Patient BA paid cash for
10 his prescriptions. Review of CURES showed therapy duplication based on the number of opiates
11 and tranquilizers dispensed. Patient BA received numerous prescriptions for HC/AP 10/325 mg
12 and Methadone prescribed by Dr. Diaz on or around the same time he had them dispensed at
13 different pharmacies. Most pain medication was prescribed by Dr. Diaz, despite him not being a
14 pain specialist. In March of 2010, for example, Patient BA received 1200 tablets of HC/AP
15 10/325 within 30 days. He received 13,000 mg per day of Acetaminophen, well above the
16 recommended dose of 4,000 mg per day. In February of 2011, for example, Patient BA received
17 720 tablets of HC/AP 10/325. He received 7800 mg per day of Acetaminophen;

18 c. Patient KB saw 5 prescribers and went to 11 pharmacies from January 1, 2009 to
19 April 8, 2013, including in Carpinteria, Hollywood, Lompoc, Santa Barbara and Solvang. He
20 lived in Santa Inez and traveled approximately 31.99 miles to Santa Barbara to see prescriber Dr.
21 Diaz. LM Caldwell-State Street was approximately 29.10 miles from Patient VA's home and
22 1.85 miles from Dr. Diaz's office. Patient VA paid cash for his prescriptions. Review of CURES
23 showed therapy duplication based on the number of opiates and tranquilizers dispensed. He
24 received most pain medication from Dr. Diaz, despite him not being a pain specialist. Patient KB
25 was dispensed 595 tablets of Oxycodone 30 mg in one month in Prescriptions 788268, 788632
26 and 789490. Patient KB, for example, was dispensed Oxycodone 30 mg at both Respondent L M
27 Caldwell- State Street and at Respondent L M Caldwell- Pueblo Street on June 18, 2010, October
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1 5, 2010, November 2, 2010 and November 29, 2010. Patient KB was placed on Suboxone, used
2 for the treatment of narcotic addiction, prior to going to LM Caldwell Pharmacists- State Street;

3 d. Patient LD saw 4 prescribers and went to 2 pharmacies from January 1, 2009 to April
4 8, 2013, including in Carpentaria, Hollywood, Lompoc, Santa Barbara and Solvang. Patient LD
5 lived in Santa Barbara and paid cash for his prescriptions. Review of CURES showed therapy
6 duplication based on the number of opiates and tranquilizers dispensed. He received most pain
7 medication from Dr. Diaz, despite him not being a pain specialist. While going to LM Caldwell
8 Pharmacist-State Street, Patient LD mainly saw Dr. Diaz but saw two prescribers after Dr. Diaz.
9 Several questionable prescriptions were filled including: Prescription No. 773360(HC/AP) and
10 773361 (HC/ibuprofen) which were both dispensed on September 21, 2010 and both had
11 hydrocodone; Prescription Nos. 789181 (HC/ Ibuprofen), 789182 (Oxycodone/Ibuprofen) and
12 789180 (Oxycodone) were all dispensed on August 23, 2011 and contained the same drugs; and
13 Prescription Nos. 790459, 790460 and 790458 had dates that were not written in the prescriber's
14 handwriting; Prescription No. 792432 (Lorazepam) was for a large quantity of 300 pills and
15 Respondent dispensed 120 pills and did not verify with the prescribers;

16 e. Patient TF saw 1 prescriber, Dr. Diaz, and went to 8 pharmacies January 1, 2009 to
17 April 8, 2013, including in Lompoc, Goleta, San Luis Obispo, Santa Maria and Orcutt. He lived
18 in Santa Barbara and paid cash for his prescriptions Review of CURES showed therapy
19 duplication based on the number of opiates and tranquilizers dispensed;

20 f. Patient JH saw 4 prescribers and went to 12 pharmacies from February 13, 2009 to
21 April 8, 2013. He saw prescribers in Santa Barbara, Lompoc and Temecula and went to
22 pharmacies in Santa Maria, Santa Barbara, Temecula, Buelton, and Lompoc. He lived in Santa
23 Maria and traveled approximately 61.53 miles to Santa Barbara to see prescriber Dr. Diaz. LM
24 Caldwell-State Street was approximately 58.68 miles from Patient JH's home and 1.85 miles
25 from Dr. Diaz's office. Patient JH paid cash for his prescriptions. Review of CURES showed
26 therapy duplication based on the number of opiates and tranquilizers dispensed. He received only
27 pain medication from Dr. Diaz, despite him not being a pain specialist. He did not have
28 significant pain history one month prior to February 2009 and had a history of Anxiety 8 months

1 prior to August 2009 and before seeing Dr. Diaz. Respondent LM Caldwell Pharmacist-State
2 Street should have questioned the following prescriptions dispensed to Patient JH on November
3 25, 2011: Prescription Nos. 793748 (Morphine Sulfate 30 mg), 793749 (Methadone 10
4 mg), 793750 (HC/AP 10/325 mg), 793751 (Oxycodone 30 mg), 793756 (Hydromorphone 8 mg),
5 793757 (Alprazolam 2 mg). Records also show that the quantity and therapy duplication
6 combination was reduced from November 30, 2009 to September 22, 2010, during the period that
7 JH did not go to Dr. Diaz. He again began to receive large quantities and therapy duplication
8 combinations when he went back to Dr. Diaz on September 30, 2010.

9 g. Patient MM saw 19 prescribers and went to 20 pharmacies from January 1, 2009 to
10 April 8, 2013. She went to prescribers in Santa Barbara, Lompoc, Stanford, Encinitas, Santa
11 Maria, Solvang, San Luis Obispo and San Francisco and went to pharmacies in Santa Barbara,
12 Lompoc, Orcutt, San Luis Obispo, Pismo Beach, Buelton, and Santa Maria. He lived in Lompoc
13 and traveled approximately 56.30 miles to Santa Barbara to see prescriber Dr. Diaz. LM
14 Caldwell-State Street was approximately 53.69 miles from Patient MM's home and 1.85 miles
15 from Dr. Diaz's office. Patient MM paid cash and paid through insurance for his prescriptions.
16 For example, he paid \$2,585.80 for Oxycontin 60 mg (Prescription No. 319145). Review of
17 CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed.
18 MM received numerous prescriptions for Oxycontin prescribed by Dr. Diaz on or around the
19 same time and went to different pharmacies to get dispensed, including LM Caldwell Pharmacist-
20 Pueblo Street;

21 h. Patient SM saw 7 prescribers and went to 11 pharmacies from January 1, 2009 to
22 April 8, 2013, including L M Caldwell- Pueblo Street. He lived in Santa Barbara and paid cash
23 for his prescriptions. Review of CURES showed therapy duplication based on the number of
24 opiates and tranquilizers dispensed. L M Caldwell- State Street dispensed questionable
25 prescriptions for Oxycodone in which instructions for use seemed too high (including receiving
26 16-24 tablets per day), including Prescription Nos. 782797, 777041, 789979 and 786575. Patient
27 SM was placed on Suboxone, used for the treatment of narcotic addiction, after no longer seeing
28

1 Dr. Diaz. SM received only pain and anxiety medication from Dr. Diaz, despite him not being a
2 pain specialist;

3 i. Patient SS saw 2 prescribers and went to 4 pharmacies from January 1, 2009 to April
4 8, 2013. He lived in Santa Barbara and paid cash for his prescriptions when insurance did not
5 cover the cost. Review of CURES showed therapy duplication based on the number of opiates
6 and tranquilizers dispensed. He showed no significant pain or anxiety history prior to
7 11/23/2010. L M Caldwell- State Street dispensed the following questionable prescriptions:
8 Prescription Nos. 780807 and 783547 for Fentanyl patches above the recommended dosing
9 interval of 72 hours. The pharmacy dispensed it for every 48 hours; Prescription Nos. 79027,
10 790597, 782251, and 782250 in which the patient received Diazepam 10 mg and Alprazolam 2
11 mg at the same time. Patient SS received most pain medication from Dr. Diaz, despite him not
12 being a pain specialist;

13 j. Patient JS saw 4 prescribers and went to 4 pharmacies from January 1, 2009 to April
14 8, 2013. He lived in Lompoc and traveled approximately 55.98 miles to Santa Barbara to see
15 prescriber Dr. Diaz. LM Caldwell-State Street was approximately 53.37 miles from Patient JH's
16 home and 1.85 miles from Dr. Diaz's office. Patient JS had the same address as Patient NS.
17 Review of CURES showed therapy duplication based on the number of opiates and tranquilizers
18 dispensed. Prior to going to LM Caldwell Pharmacist-State Street, Patient JS went to multiple
19 pharmacies for Dr. Diaz's prescriptions. There was no significant pain history 6 months prior to
20 June 18, 2009 and Dr. Diaz. Patient JS received only pain and anxiety medication from Dr. Diaz,
21 despite him not being a pain specialist;

22 k. Patient NS saw 3 prescribers and went to 5 pharmacies from January 1, 2009 to April
23 8, 2013. He lived in Lompoc and traveled approximately 55.98 miles to Santa Barbara to see
24 prescriber Dr. Diaz. LM Caldwell-State Street was approximately 53.37 miles from Patient NS's
25 home and 1.85 miles from Dr. Diaz's office. Patient NS had the same address as Patient JS.
26 Patient NS paid cash for his prescriptions when the cost was not covered by insurance. Review of
27 CURES showed therapy duplication based on the number of opiates and tranquilizers dispensed.
28 Prior to going to LM Caldwell Pharmacist-State Street, Patient JS went to multiple pharmacies for

1 Dr. Diaz's prescriptions. While going to L M Caldwell Pharmacist- State Street, he continued to
2 use other pharmacies. Patient NS received only pain and anxiety medication from Dr. Diaz,
3 despite him not being a pain specialist;

4 l. Patient VS saw 3 prescribers and went to 5 pharmacies from January 1, 2009 to April
5 8, 2013, including LM Caldwell Pharmacist-State Street. He lived in Lompoc a and traveled
6 approximately 55.47 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-State Street
7 was approximately 52.86 miles from Patient VS's home and 1.85 miles from Dr. Diaz's office.
8 Patient VS paid cash for his prescriptions when the cost was not covered by insurance. Patient
9 VS paid over \$200.00 for Oxycodone several times. Review of CURES showed therapy
10 duplication based on the number of opiates and tranquilizers dispensed. Patient VS went to
11 multiple pharmacies for Dr. Diaz's prescriptions. L M Caldwell - State Street dispensed the
12 following questionable prescriptions: Hydromorphone 8 mg and Hydromorphone 4 mg were
13 dispensed on January 1, 2011, February 2, 2011, March 2, 2011, March 30, 2011 and April 27,
14 2011. Oxycodone 30 mg and Oxycodone 5 mg was dispensed on April 27, 2011. The different
15 strength of the prescriptions should have been red flags. Patient VS received only pain and
16 anxiety medication from Dr. Diaz, despite him not being a pain specialist;

17 m. Patient CW saw 2 prescribers and went to 2 pharmacies from January 1, 2009 to April
18 8, 2013. Patient CW lived in Santa Barbara and paid cash when the cost was not covered by
19 insurance. Review of CURES showed therapy duplication based on the number of opiates and
20 tranquilizers dispensed. Respondent L M Caldwell- State Street dispensed questionable
21 prescriptions, including the following: Amphetamine 30 mg and Amphetamine 20 mg dispensed
22 at same time in Prescription Nos. 772453, 772454, 773785, 773783, 775368, 775363, 776678,
23 776679, 780924, 780923, 779437, 779438, 771122 and 771123 and Suboxone was prescribed by
24 Dr. Diaz for pain on numerous occasions. Patient CW received mostly pain, and anxiety
25 medications prescribed by Dr. Diaz, despite him not being a pain specialist.

26 ///

27 ///

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1 50. L M Caldwell Pharmacist-State Street and Respondent Caldwell did not know the
2 diagnosis for patients VA, BA, KB, CD, LD, TF, JH, MM, AM, SM, SS, JS, NS, VS, and CW,
3 and knew that Dr. Diaz was a family practitioner and not a pain management physician. Also, L
4 M Caldwell Pharmacist-State Street and Respondent Caldwell failed to maintain records or files
5 on drug therapy for these patients.

6 51. When reviewing the records for patients VA, BA, KB, CD, LD, TF, JH, MM, AM,
7 SM, SS, JS, NS, VS, and CW, it was noted that nine out of these fifteen patients lived outside Dr.
8 Diaz's and LM Caldwell Pharmacist-State Street's normal trading area . Due to the number of
9 readily accessible pharmacies throughout California, the common trading area is considered to be
10 5 miles. The range of distance travelled for the selected patients was between 3.7 miles for the
11 shortest to 122.06 for the longest. The average distance traveled by the patient was 59.18 miles
12 and the total distance these patients travelled to obtain controlled substances was excessive. Four
13 of the fifteen patients' home addresses were not recognized by Mapquest. Two patients had the
14 same address, NS and JS.

15 52. Respondent LM Caldwell Pharmacist-State Street dispensed a total of 11,817
16 controlled substances prescriptions from January 1, 2011 to December 5, 2012 and 1,492 were
17 prescribed by Dr. Diaz. 31.64 % (407 out of 1,492) of Dr. Diaz' patients paid cash, including
18 when the medication was not covered by their insurance or to get early refills. Some patients had
19 insurance/Medicaid, however, were willing to pay a large sum of cash for controlled substances
20 which were not covered by the plans, including those on Medicaid.

21 53. There was excessive furnishing of controlled substances prescribed by Dr. Diaz. The
22 dispensing ratio of prescriptions by Dr. Diaz by L M Caldwell Pharmacists-State Street and
23 Respondent Caldwell was greatly unbalanced when compared to other neighboring pharmacies,
24 including the following three pharmacies: Federal Drugs PHY37078 (located 1.92 miles from L
25 M Caldwell Pharmacist-State Street), Rite-Aid #5785 PHY 42255 (located 1.65 miles from L M
26 Caldwell Pharmacist-State Street), and CVS#9392 PHY 494473 (located .41 miles from L M
27 Caldwell Pharmacist-State Street). L M Caldwell Pharmacist-State Street filled tens of
28 thousands more controlled substances prescribed by Dr. Diaz when compared to neighboring

1 pharmacies for the time period specified of January 1, 2011 through December 5, 2012. The
 2 CURES data for the L M Caldwell Pharmacists-State Street and three surrounding pharmacies,
 3 for example, was as follows:

4 Pharmacy	5 Total controlled 6 substances 7 dispensed 8 between 9 1/1/2011- 10 12/5/2012	11 Total Dr. Diaz's 12 RX from 13 1/1/2011-12/5/ 14 2012	15 Total quantity 16 for Dr. Diaz's 17 RX from 18 1/1/2011- 19 12/5/2012	20 % of total 21 controlled 22 substance RX 23 dispensed for 24 Dr. Diaz
25 Respondent LM 26 Caldwell 27 Pharmacist – 28 State Street	11, 817	1,492	195,041	12.62%
29 Federal Drugs 30 PHY 37078 31 (1.92 miles from 32 LM Caldwell)	18, 282	0	0	0%
33 Rite-Aid #5785 34 PHY 42255 35 (.065 miles from 36 LM Caldwell 37 Pharmacist	3,584	0	0	0%
38 CVS # 9392 39 PHY 49473 40 (.41 miles from 41 LM Caldwell)	13,365	44	6,599	.33%

18 **Pattern of Early Refills and Duplicate Medications**

19 54. Between January 1, 2010 and December 5, 2012, LM Caldwell- State Street engaged
 20 in a pattern of early refills, including for patients KB, CD, LD, TF, JH, AM, SM, NS, VS, and
 21 CW, including, for example, 23 days early for patient LD (prescription Nos. 764100 & 764468),
 22 29 days early for patient AM (prescription Nos. 791702 & 793219), 21 days early for patient SM
 23 (prescription Nos. 786128 & 786573), and 14 days early for patient CW (prescription Nos.
 24 782792 & 782792).

1 55. Also, the patient profile from 2010 to 2012 for patient SS,⁴ for example, showed
2 numerous therapy duplicate medications prescribed by Dr. Diaz and dispensed by L M Caldwell
3 Pharmacists- State Street and Respondent Caldwell⁵. The profile showed the following:

4 a. On January 18, 2011, when L M Caldwell Pharmacists-State Street started dispensing
5 Fentanyl 100 mcg/hr to Patient SS (Prescription No. 778213), the pharmacists should have
6 questioned the high doses of Fentanyl and whether Patient SS was previously on Fentanyl 100
7 mcg/hr prior to getting his prescription from L M Caldwell Pharmacist-State Street;

8 b. Patient SS was prescribed Methadone 3 tablets every twelve (12) hours on July 19,
9 2011 and on August 17, 2011 (Prescription Nos. 787609 & 788989) and each month thereafter,
10 his dose was increased, four (4) tablets every twelve (12) hours on September 22, 2011
11 (Prescription No. 790594), and five (5) tablets every 12 hours on October 27, 2011 (Prescription
12 No. 792268);

13 c. On March 15, 2011, ten (10) patches of Fentanyl 100 mcg/hr were dispensed, each
14 for a thirty (30) day supply (Prescription No. 780807). Seven days later, on March 22, 2011,
15 another 10 patches of Fentanyl 100 mcg/hr were prescribed and entered as a file only as "FO"
16 (Prescription No. 782067);

17 d. On March 22, 2011, Prescription No. 784841 for Morphine Sulfate 10 mg/5ml
18 solution was written with no quantity written on the prescription, but the quantity box of "151 &
19 over" was marked and 360 mls were dispensed by Respondent L M Caldwell-State Street and
20 Respondent Caldwell. This prescription was incomplete and the prescriber, Dr. Diaz, should have
21 been contacted and the quantity documented after clarification from the prescriber;

22 e. On May 20, 2011, Patient SS was prescribed three different narcotic pain
23 medications: Hydromorphone 8 mg one tablet daily (Prescription No. 784840) with Fentanyl 100
24 mcg/hour patch every forty-eight (48) hours (Prescription No. 784839) and Morphine Sulfate 10
25

26 ⁴ Patient SS died in May 2012 allegedly as a result of a drug overdose.

27 ⁵ No prescriptions were dispensed by Respondent L M Caldwell-State Street or
28 Respondent Caldwell for Patient SS from January 10, 2010 to December 30, 2010.

1 mg, 5ml every two (2) to four (4) hours (Prescription No. 784841). Prescription No. 784839 was
2 dispensed by Respondent L M Caldwell-State Street and Respondent Caldwell, for Fentanyl 100
3 mcg/hour with directions to apply every forty-eight (48) hours. However, the manufacturer's
4 direction was to change the patch every seventy-two (72) hours;

5 f. On July 18, 2011, Prescription No. 787610 for Morphine 20 mg/ml solution was
6 written for 400 mls, but 360 mls was dispensed. This was a variation from the quantity
7 prescribed;

8 **Exceeding the Day Supply For Controlled Substance Refills**

9 56. The patient profile from 2010 to 2012 for patient SS, also showed that the day supply
10 was exceeded for controlled substance refills, for example, as follows:

11 a. A review of SS patient profile revealed that alprazolam and diazepam, classified as
12 benzodiazepines were also dispensed from December 2010 to September 2011. Prescription No.
13 782251 for Alprazolam, a Schedule IV controlled substance, was originally dispensed on March
14 25, 2011 for a 30 day supply. Prescription No. 782251 was then refilled five times, each for a 30
15 day supply, on April 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011
16 by Respondent L M Caldwell-State Street and Respondent Caldwell. A total of 150-day supply
17 was dispensed, exceeding a 120-day supply as required by Health and Safety code section 11200;

18 b. Prescription No. 782250 for Diazepam, a schedule IV controlled substance, was
19 originally dispensed on March 25, 2011 then refilled five times, each for a 30 day supply, on
20 April 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011 by Respondent
21 L M Caldwell-State Street and Respondent Caldwell. A total of 150-day supply was dispensed,
22 exceeding a 120-day supply as required by Health and Safety code section 11200.

23 **Patient JJ**

24 57. On September 12, 2013, the Board received a report of settlement judgment or
25 arbitration award, San Bernardino Superior Court, Case No. 2012-112565, regarding Patient JJ,
26 from Liberty Insurance Underwriter, Inc. for Respondent Caldwell, without the admission of
27 guilt. Improper Management and dispensing of controlled substance resulting in addiction and
28 death was alleged in the civil suit. Patient JJ presented prescriptions from a medical doctor

1 which Respondent Caldwell dispensed. Patient JJ alleged that she became addicted to drugs
2 because Respondent Caldwell dispensed the prescriptions to her.

3 58. A review of Respondent L M Caldwell Pharmacists-State Street's profile for Patient
4 JJ revealed that she was mostly dispensed controlled substances by Respondent Caldwell which
5 were prescribed by Dr. Diaz, who was not a pain specialist. A review of CURES revealed that
6 Patient JJ went to multiple doctors at the same time and had prescriptions dispensed at multiple
7 pharmacies during the same time period. Patient JJ received numerous refills and received above
8 the recommended dose of 400 mg per day of Acetaminophen. On certain months, Patient JJ
9 received over 600 tablets of Hydrocodone. If Respondent Caldwell would have checked
10 CURES, he would been able to determine JJ was going to several pharmacies and several doctors.
11 Respondent Caldwell knew that patient was getting drugs from Dr. Diaz, prior to being indicted,
12 and then continued to dispense prescriptions from other doctors to this patient.

13 59. Patient JJ had a pattern of early refills on Oxycodone 30 mg, for the management of
14 moderate to severe pain, and Morphine Sulfate 30 mg, for the management of severe pain. Both
15 medications are for the immediate relief of pain. LM Caldwell Pharmacist-State Street and
16 Respondent Caldwell failed to contact the prescriber to determine the logic of this combination.
17 Also, Prescription Nos. 768630 and 768631 were dated July 1, 2010. LM Caldwell Pharmacist-
18 State Street and Respondent Caldwell received and dispensed them on June 11, 2010.

19 60. From January 1, 2010 to January 1, 2013, Patient JJ had 145 prescriptions for
20 controlled substances dispensed from various prescribers and pharmacies. 85 of the 145
21 prescriptions (58.96 %) were for cash.

22 61. From January 1, 2010 to January 1, 2013, LM Caldwell Pharmacist-State Street and
23 Respondent Caldwell failed to assume their corresponding responsibility when they failed to
24 appropriately scrutinize Patient JJ's drug therapy with readily available tools such as CURES
25 reports and its own pharmacy records. Respondents should have looked at the repetitive
26 prescribing pattern for highly abused controlled substances, the location of prescriber's practice in
27 relation to the location of JJ's residence, and Patient's payment methods. As a result,
28 Respondents dispensed controlled substances for Patient JJ who was habitually engaged in doctor

1 shopping and multiple pharmacy activity. Respondents should have questioned the legitimacy of
2 Prescriptions, including Prescription Nos. 758920, 767530, 767531, 768630, 768631, 758920 (for
3 1/18/2010, 3/19/2010, 2/18/2011, 2/18/2011), 782598 (for 4/1/2011, 5/17/2011), 803536, 803537,
4 803963,803965, 803966, 805071, 805072, 805074, 806756, 806757, 807683, 807684, 807699
5 and 807700.

6 **Patient AM**

7 62. On February 3, 2014, the Board received a report of settlement judgment or
8 arbitration award, Case No. 1414079, regarding Patient AM, from Chicago Insurance Company
9 for Respondent Caldwell- State Street, without the admission of guilt. Patient AM, presented a
10 prescriptions from a medical doctor which Respondent Caldwell dispensed. On November 25,
11 2011, Patient AM died from acute complications from narcotic abuse.

12 63. A review of Respondent L M Caldwell Pharmacist-State Street's profile for Patient
13 AM revealed that Patient AM received the following controlled substances, that were prescribed
14 by Dr. Diaz, at LM Caldwell Pharmacists-State Street, and had a pattern of being dispensed early:

15

RX Dispensed	RX #	QTY	Day Supply	Date dispensed	RX#	QTY	Day Supply	Days Early from Prior RX
10/24/11	792077	120	30	11/14/11	793124	120	30	9 days
11/14/11	793104	150	19	11/15/11	793216	90	30	19
11/15/11	793105	150	19	11/15/11	793218	90	30	19
11/15/11	791702	120	30	11/15/11	793219	60	20	29

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21 64. The Board could not find the exact patient address on Mapquest in Solvang,
22 California. Patient AM traveled 35.56 miles from Solvang to Santa Barbara where Dr. Diaz was
23 located. Patient AM lived approximately 70.09 miles away from Respondent LM Caldwell-State
24 Street. Patient AM paid cash for his medication and Dr. Diaz was the prescriber. Respondents
25 did not have access to CURES during the time Dr. Diaz dispensed to AM so it was not accessed.
26 The pharmacy did not have a process to validate the prescriptions. As long as the Dr. wrote the
27 prescription, the pharmacy dispensed it.
28

1 65. A review of Respondent L M Caldwell Pharmacist-Pueblo Street's profile for Patient
2 AM and CURES records also revealed that Patient AM saw 4 prescribers and went to 8
3 pharmacies from January 1, 2009 to April 8, 2013. Patient AM saw prescribers in Santa Barbara,
4 Solvang, and Shell Beach. Patient AM received only pain medication from Dr. Diaz, despite him
5 not being a pain specialist.

6 66. LM Caldwell Pharmacist-State Street and Respondent Caldwell would have been
7 able to determine there were unusual prescribing patterns for Dr. Diaz and that Patient AM was
8 going to multiple pharmacies. While going to L M Caldwell Pharmacist-State Street, Patient AM
9 went to multiple pharmacies and received multiple prescriptions for Hydrocodone 8 mg on or
10 around the same time from Dr. Diaz which AM dispensed at different pharmacies. For example:

11 a. On February 23, 2010, he received Hydrocodone (#60-5 day supply) dispensed at
12 Sansum Clinic, Prescription No. 2272072, and Hydrocodone (#200-17 day supply) at The
13 Medicine Shoppe Prescription No. 1142240;

14 b. On October 14, 2010, he received Hydrocodone (#60-4 day supply) dispensed at
15 Sansum Clinic, Prescription No. 2277704, and Hydrocodone (#260-21 day supply) at LM
16 Caldwell Pharmacists-Pueblo Street, Prescription No. 322231;

17 c. On January 5, 2011, he received Hydrocodone (#180-16 day supply) dispensed LM
18 Caldwell Pharmacist-Pueblo Street, Prescription No. 324789, and on January 7, 2011, he received
19 Hydrocodone (#180-30 day supply) at LM Caldwell Pharmacists-State Street, Prescription No.
20 778577;

21 d. On November 11, 2011, he received Hydrocodone (#120-15 day supply) dispensed
22 LM Caldwell Pharmacist-Pueblo Street, Prescription No. 609846. On November 14, 2011, he
23 received Hydrocodone (#150- 19 day supply) at LM Caldwell Pharmacists-State Street,
24 Prescription No. 793104. On November 15, 2013, he received Hydrocodone (#90-30 day supply)
25 dispensed at LM Pharmacist – State Street, Prescription No. 793216.

26 67. While going to L M Caldwell Pharmacist –State Street, Patient AM went to multiple
27 pharmacies and received multiple prescriptions for Oxycodone 30 mg on or around the same time
28 from Dr. Diaz which Patient AM had dispensed at different pharmacies. For example:

1 a. On July 21, 2010 he received Oxycodone (#60-15 day supply) dispensed at Sansum
2 Clinic Pharmacy, Prescription No. 2275679 and on July 26, 2010 he received Oxycodone (#60-
3 15 day supply) dispensed at L M Caldwell Pharmacist - State Street, Prescription No. 770660;

4 b. On January 5, 2011, he received Oxycodone (#180-15 day supply) dispensed at LM
5 Caldwell Pharmacist-State Street, Prescription No. 324788, and on January 7, 2011, he received
6 Oxycodone (#180-15 day supply) at LM Caldwell Pharmacists-State Street, Prescription No.
7 778578;

8 c. On November 11, 2011, he received Oxycodone (#97-12 day supply) dispensed at
9 San Ysidro Pharmacy, Prescription No. 609848. On November 14, 2011, he received Oxycodone
10 (#150- 19 day supply) at LM Caldwell Pharmacists-State Street, Prescription No. 793105. On
11 November 15, 2013, he received Oxycodone (#90-30 day supply) dispensed at LM Pharmacist –
12 State Street, Prescription No. 793218.

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1 **LM CALDWELL PHARMACIST-PUEBLO STREET AND RESPONDENT**

2 **YAHYAVI**

3 **Records of Acquisition, Disposition and Storage of Drugs**

4 68. Between December 18, 2010 and December 17, 2012, Respondent L M Caldwell
5 Pharmacist-Pueblo Street and Respondent Yahyani could not account for an inventory overage of
6 53,811 tablets of HC/AP 10/325 mg.

7 69. On January 16, 2013, LM Caldwell Pharmacist - Pueblo Street and Respondent
8 Yahyavi were unable to provide the original prescription documents for RX # 327435, 334405,
9 317892, 317893, 317894, 330297, 323526, 324203, 325803, 325881, 312027, 316180, 315861,
10 322717, 322718, 319209, 322715, 330610, 333178, 334336, 318220, 331648, 322460, 332461,
11 326892, 327949, 332102, and 336005.

12 **Furnishing and Purchasing of Dangerous Drugs or Devices Without Adequate**

13 **Sales and Purchase Records**

14 70. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell
15 Pharmacist-Pueblo Street purchased HC/AP 10/325 mg from Respondent L M Caldwell
16 Pharmacist-State Street without adequate purchase records.

17 **Variation from Prescription Without Prior Consent of Prescriber**

18 71. Review of prescriptions from January 1, 2010 to January 15, 2013 revealed that
19 Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi deviated from the
20 requirements of a prescription without the prior consent of the prescriber. Specifically, between
21 January 1, 2010 and January 15, 2013, they dispensed the following prescriptions incorrectly:

22 a. Prescription No. 321310, was for Oxycodone 30 mg 1-2 every 6 hour as needed for
23 pain. Respondents dispensed it as 1 tablet four times daily as needed for pain;

24 b. Prescription No. 321312, was for Xanax mg 1-2 times daily for panic. Respondents
25 dispensed it as 1 tablet four times daily;

26 c. Prescription No. 325038, was for 30 mg 1-2 HC/AP 7.5/750 mg. Prescriber wrote 1
27 tablet every 6 hours as needed for pain and Respondents dispensed it as 1 tablet every 4-6 hours
28 as needed for pain;

1 d. Prescription No. 331728, was for Dilaudid 8 mg, 1 every 6 hours #120. Respondents
2 dispensed Hydromorphone 8 mg, 1-2 tablets every 6 hours;

3 e. Prescription No. 332908, was for Methadone 10 mg 7 tablets every 12 hours #400.
4 Respondents dispensed it as 6 tablets every 12 hours;

5 f. Prescription No. 335645, was for Oxycodone IR 30 mg 1 tablet every 4-6 hour.
6 Respondents dispensed Oxycodone IR 30 mg 1 tablet every 6 hours.

7 **Dispensing The Balance of Schedule II Prescriptions Beyond 72 hours**

8 72. Review of prescriptions, from January 1, 2010 to January 15, 2013, revealed that
9 Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi partially filled
10 prescriptions for controlled substances listed in Schedule II and then dispensed the balance of the
11 prescription after the 72 hour period allowed for dispensing the balance of prescriptions.
12 Specifically between January 1, 2010 to January 15, 2013, Respondents dispensed Prescription
13 Nos. 329771, 331396, 332230, and 33265, then dispensed the balance of the prescriptions after 72
14 hours.

15 **Prescriptions Dispensed by L M Caldwell Pharmacist- Pueblo Street and**
16 **Respondent Yahyavi**

17 73. Between January 1, 2011 and December 5, 2012, L M Caldwell Pharmacist-Pueblo
18 Street and Respondent Yahyavi dispensed at total of 11,215 controlled substance prescriptions of
19 which 1,418 prescriptions were written by Dr. Diaz. The prescriptions were dispensed without
20 regard to the following factors:

21 (1) Pattern of patients willing to drive long distance to obtain controlled substance
22 prescriptions from Dr. Diaz and to fill the prescriptions at L M Caldwell Pharmacists and other
23 pharmacies;

24 (2) Percentage of cash patients specific to listed prescribers and pattern of patients
25 willing to pay cash for highly expensive prescriptions when insurance did not cover;

26 (3) Same or similar prescribing patterns for multiple patients, including at least three
27 opiates and one to two tranquilizers;

28 (4) Irregular pattern of early refills/ patient returning too frequently.

1 74. Respondent L M Caldwell Pharmacists- Pueblo Street and Respondent Yahyavi
2 failed to appropriately scrutinize patients' drug therapy with readily available tools such as
3 CURES⁶ reports and its own pharmacy records. Respondents did not have a process to validate
4 prescriptions. As a result, they repeatedly dispensed controlled substances early in certain
5 instances to patients who habitually engaged in doctor shopping and multiple pharmacy activity.
6 Questionable drug therapies were visible from Respondent L M Caldwell- Pueblo Street's own
7 records and showed the prescribing pattern of Dr. Diaz was repetitive and redundant with respect
8 to the same controlled substances prescribed repeatedly for the majority of his patients. His
9 prescribing habits included numerous large quantities of opiates in combination with minor
10 tranquilizers. Patients received on average three to four pain medications with one to two anti-
11 anxiety drugs. The patients included, but were not limited to GA, RB, CB, CC, JF, CG, GJ, IJ,
12 ML, KM, MM, SP, VS, MS, and RS. Four of these patients were on Suboxone/Subtex, used for
13 treating opiate addiction, prior to, during and/or after treatment by Dr. Diaz. A review of CURES
14 and their own records would have been a red flag for Respondents. For example:

15 a. Patient GA went to 4 prescribers, in Goleta and Santa Barbara, and 3 pharmacies in
16 Santa Barbara from January 1, 2009 to April 9, 2013. Patient GA had no anxiety history prior to
17 April 21, 2011 and prior to seeing Dr. Diaz. However, Dr. Diaz started him with a high dose of
18 Alprazolam 2 mg. Patient VA paid cash for his prescriptions when insurance did not cover the
19 cost. Review of CURES showed therapy duplication based on the number of opiates and
20 tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions dispensed at LM
21 Caldwell Pharmacist- Pueblo Street. Most pain medication was prescribed by Dr. Diaz, despite
22 him not being a pain specialist. He received numerous prescriptions for HC/AP 10/325 mg and
23 Methadone prescribed by Dr. Diaz on or around the same time he had them dispensed at different
24 pharmacies. In the month of August 2010, for example, Patient VA received 960 tablets of
25 HC/AP 10/325 mg within 30 days and received 10,400 mg per day, well above the recommended
26 dose (of Acetaminophen) of 4,000 mg per day. In July of 2011, for example, Patient VA

27 ⁶ Respondent Yahyavi advised the Board that he obtained access to CURES at the end of
28 2011.

1 received 1,080 tablets of HC/AP 10/325 mg within 30 days. Patient VA received 13,000 mg per
2 day. In January of 2011, for example, Patient VA received a 30 day supply of Methadone 10 mg
3 from one pharmacy and then received another 30 day supply from another pharmacy, LM
4 Pharmacist- Pueblo Street, ten days later on, January 25, 2011;

5 b. Patient RB went to 3 prescribers in Santa Barbara and 4 pharmacies, in Ojai and
6 Santa Barbara from January 1, 2009 to April 9, 2013. He lived in OakView and traveled
7 approximately 30.33 miles to Santa Barbara to see prescriber Dr. Diaz. LM Caldwell-Pueblo
8 Street was approximately 33.17 miles from Patient RB's home and 2.88 miles from Dr. Diaz's
9 office. Patient RB paid cash for his prescriptions and paid over \$200.00 for Oxycodone and
10 Hydromorphone. Review of CURES showed therapy duplication based on the number of opiates
11 and tranquilizers dispensed. He mainly went to Dr. Diaz while having prescriptions dispensed at
12 LM Caldwell Pharmacist- Pueblo Street. Most pain medication was prescribed by Dr. Diaz,
13 despite him not being a pain specialist. The following prescriptions dispensed by LM Caldwell
14 Pharmacists-Pueblo Street for Oxycodone were questionable: Prescription Nos. 347843, 347918,
15 and 338143 were written by Dentist Jeff Peppard;

16 c. Patient CB went to 4 prescribers in Santa Barbara and 11 pharmacies, in Ojai and
17 Santa Barbara, Port Hueneme, Sacramento and St. Louis Missouri from January 1, 2009 to April
18 9, 2013. He lived in Santa Barbara (although the exact address he listed could not be found
19 through mapquest) and paid cash for his prescriptions. Review of CURES showed therapy
20 duplication based on the number of opiates and tranquilizers dispensed. He mainly went to Dr.
21 Diaz while having prescriptions dispensed at LM Caldwell Pharmacist- Pueblo Street. Most pain
22 and anxiety medication was prescribed by Dr. Diaz, despite him not being a pain specialist. CB
23 received multiple prescriptions for HC/AP 10/325 mg and Alprazolam @mg on or around the
24 same time by Dr. Diaz which he had dispensed at different pharmacies, including for example:
25 On March 26, 2010 Patient CB received HC/AP 10/325 #200 (25 day supply) dispensed at Rite
26 Aid #5782 (Prescription No. 676053) and on April 9, 2010 he received HC/AP 10/325#240(30
27 day supply) dispensed at LM Caldwell Pharmacists-Pueblo Street (Prescription No. 316460). The
28 prescriptions were refilled again at Ride Aid on April 29, 2010, May 29, 2010, June 14, 2010,

1 July 10, 2010 and at L M Caldwell- Pueblo Street on May 24, 2010 and July 15, 2010. Patient
2 CB received 440 tablets of HC/AP in 30 days, 5200 mg per day of Acetaminophen, well above
3 the recommended 4,000 mg dose per day. In addition, September 27, 2010, L M Caldwell
4 Pharmacists- Pueblo Street received 2 different prescriptions for Oxycodone 30 mg form Dr.
5 Diaz's office for Patient CB. After Dr. Diaz was investigated, Patient CB did not get any
6 prescriptions dispensed at L M Caldwell Pharmacist-Pueblo Street nor did patient CB have any
7 significant history of pain or anxiety drug treatment.

8 d. Patient CC went to 22 prescribers and 13 pharmacies from January 1, 2009 to April 9,
9 2013. He went to prescribers in Bakersfield, Goleta, Isla Vista, Long Beach, Santa Barbara and
10 Santa Maria. He went to pharmacies in Goleta, Santa Barbara, Torrance and Wilmington. Prior
11 to and while going to L M Caldwell Pharmacist-Pueblo Street, Patient CC went to numerous
12 prescribers and pharmacies. He lived in Goleta (although the exact two addresses he listed could
13 not be found through mapquest) and paid cash for his prescriptions of HC/AP, Carisoprodol,
14 Oxycodone/AP and Hydromorphone. Review of CURES showed therapy duplication based on
15 the number of opiates and tranquilizers dispensed. He mainly went to Dr. Diaz while having
16 prescriptions dispensed at LM Caldwell Pharmacist-Pueblo Street. Most pain medication was
17 prescribed by Dr. Diaz, despite him not being a pain specialist. For example, Patient CC received
18 5,200 mg of Acetaminophen, an amount above the recommended dose of Acetaminophen of
19 4,000 mg in October and November of 2011 through the following prescriptions dispensed at L
20 M Caldwell Pharmacists- Pueblo Street: Prescription No. 334473 for AP/Oxycodone 10/325 mg
21 #240 (30 day supply) on October 20, 2011, Prescription No. 333957 for HC/AP 10/325 mg #240
22 (30 day supply) on October 31, 2011, Prescription No. 335134 for AP/Oxycodone 10/325 mg
23 #240 (30 day supply) on November 14, 2011, Prescription No. 333957 for AP/HC 10/325 mg
24 #240 (30 day supply) on November 23, 2011. On August 2, 2010, L M Caldwell Pharmacist –
25 Pueblo Street dispensed 2 prescriptions for Alprazolam 2 mg, Prescription No. 318318 and
26 319040 on the same day. Patient CC continued to have most of his prescriptions dispensed at L
27 M Caldwell Pharmacist- Pueblo Street after Dr. Diaz. The number of pain medications and
28 quantities were reduced.

1 e. Patient JF went to 1 prescriber, Dr. Diaz in Santa Barbara, and 4 pharmacies, in Ojai,
2 Goleta, and Santa Barbara from January 1, 2009 to April 9, 2013. He lived Santa Barbara and
3 paid for his prescriptions through insurance. Review of CURES showed therapy duplication
4 based on the number of opiates and tranquilizers dispensed. Patient JF had no significant pain
5 history one year prior to January 20, 2010 and obtaining prescriptions from Dr. Diaz. However,
6 Dr. Diaz began his treatment with Oxycontin 80 mg, Morphine Sulfate 100 mg and Oxycodone
7 30 mg. Also, Patient JF did not have a history of anxiety nine months prior to obtaining
8 prescriptions from Dr. Diaz. However Dr. Diaz began treatment with Lorazepam 2 mg. Most
9 pain medication was prescribed by Dr. Diaz, despite him not being a pain specialist. JF was
10 prescribed the long acting opiates, Opana ER, Oxycontin, and MS Contin by Dr. Diaz at the
11 same time and were dispensed by L M Caldwell Pharmacist-Pueblo Street. These long acting
12 drugs are usually not prescribed together. Patient JF did not get any prescriptions dispensed at
13 LM Caldwell Pharmacist- Pueblo Street after Dr. Diaz;

14 f. Patient CG went to 10 prescribers and 5 pharmacies in Santa Barbara from January 1,
15 2009 to April 9, 2013. She went to prescribers in Lompoc, Santa Barbara, Carpinteria and
16 Sacramento. She lived in Carpinteria and traveled 10.63 miles to get to Dr. Diaz's Office in
17 Santa Barbara and Respondent L M Caldwell Pharmacist- Pueblo Street was located 13.63 miles
18 away from Patient CG's home. Patient CG paid for her prescriptions through insurance. Review
19 of CURES showed therapy duplication based on the number of opiates and tranquilizers
20 dispensed. Patient CG mostly went to Respondent L M Caldwell Pharmacist-Pueblo Street while
21 going to Dr. Diaz. Most pain medication was prescribed by Dr. Diaz, despite him not being a
22 pain specialist. Respondent L M Caldwell Pharmacist- Pueblo Street dispensed prescriptions in
23 November 2009 through February 2010 above the 4,000 mg recommended dose of
24 Acetaminophen. Respondent L M Caldwell Pharmacist- Pueblo Street also dispensed numerous
25 prescriptions for Suboxone, used for treatment of opioid addiction, from Dr. Diaz while
26 prescribing other narcotics. Respondent L M Caldwell Pharmacist- Pueblo Street also dispensed
27 Prescription Nos. 312135, 312136, 333177, 333178, 335385, 33586 for the long action opiates,
28 Opana ER and Oxycontin. Patient CG continued to get most pain and anxiety prescriptions

1 dispensed at Respondent L M Caldwell Pharmacist-Pueblo Street after Dr. Diaz, but the quantity
2 and therapy duplication was reduced by other prescribers. Respondent L M Caldwell Pharmacist-
3 Pueblo Street dispensed Prescription Nos. 319209, 319172, 319173 which were telephoned by the
4 prescriber's office but did not note the name of the agent of the prescriber nor the pharmacist who
5 transcribed it;

6 g. Respondent L M Caldwell Pharmacist-Pueblo Street dispensed Prescription Nos.
7 337054, 337055 and 337056 with no prescriber signature and date to Patient IJ on January 3,
8 2012;

9 h. Patient ML went to 2 prescribers and 3 pharmacies, in Ojai, Goleta, and Santa
10 Barbara from January 1, 2009 to April 9, 2013. She lived in Santa Barbara (same address as
11 Patient IJ and Patient GJ) and paid cash for her prescriptions when not covered by insurance.
12 Review of CURES showed therapy duplication based on the number of opiates and tranquilizers
13 dispensed. While going to Respondent L M Caldwell Pharmacist-Pueblo Street, she mainly went
14 to Dr. Diaz. Patient ML received various HC/AP drugs prescribed by Dr. Diaz on or around the
15 same time which she had dispensed at multiple pharmacies, including Respondent L M Caldwell
16 Pharmacist- Pueblo Street. ML Received 5,166 mg per day of Acetaminophen, for example in
17 September of 2009, an amount over the recommended dose of Acetaminophen of 4,000 mg per
18 day. She received 7,100 mg per day of Acetaminophen in November, 2010 from Respondent L
19 M Caldwell Pharmacist- Pueblo Street and January 2011. Patient ML only had one pain
20 prescription dispensed at Respondent L M Caldwell Pharmacist-Pueblo Street after Dr. Diaz. A
21 review of Patient ML's Profile revealed she received mostly pain medication from Dr. Diaz, who
22 was not a pain specialist;

23 i. Patient KM went to 4 prescribers in Santa Barbara and Lompoc and 13 pharmacies
24 from January 1, 2009 to April 9, 2013. She went to pharmacies in Lompoc, Santa Barbara, Santa
25 Maria, Orcutt and San Luis Obispo. She lived in Lompoc (same address as Patient MM) and
26 traveled 55.81 miles to Dr. Diaz's office and lived 53.28 miles from Respondent L M Caldwell
27 Pharmacist- Pueblo Street. Patient KM paid cash for her prescriptions and paid over \$350.00 for
28 Oxycodone and Hydromorphone. Review of CURES showed therapy duplication based on the

1 number of opiates and tranquilizers dispensed. She received only pain and anxiety medication
2 from Dr. Diaz, despite him not being a pain specialist. On January 12, 2011, Patient KM
3 received Oxycodone #180 and January 19, 2011 received Oxycodone #60. On February 11, 2011
4 he received #180 and on February 15, 2011, he received #60. KM should have had enough
5 tablets and the unusual dosage changes should have been questioned by Respondent L M
6 Caldwell Pharmacist- Pueblo Street. Patient KM did not get any pain or anxiety prescriptions
7 dispensed at Respondent L M Caldwell Pharmacist- Pueblo Street after Dr. Diaz;

8 j. Patient MM went to 17 prescribers and 20 pharmacies from January 1, 2009 to April
9 8, 2013. She went to prescribers in Santa Barbara, Lompoc, Lodi, Encinitas, San Luis Obispo,
10 Santa Maria, Solvang and Stanford and went to pharmacies in Lompoc, Santa Barbara, Santa
11 Maria, Orcutt, Buellton, San Luis Obispo and Pismo Beach. Prior to going to Respondent L M
12 Caldwell -Pueblo Street, she went to multiple pharmacies and prescribers. She lived in Lompoc
13 (same address as Patient KM) and traveled 55.81 miles to Dr. Diaz's office and lived 53.28 miles
14 from Respondent L M Caldwell Pharmacist-Pueblo Street. Patient KM paid cash when early
15 refills were obtained and/or when medication was not covered by insurance. Patient KM paid
16 \$327.00 for Oxycodone and \$1,585.00 for Oxycontin. Review of CURES showed therapy
17 duplication based on the number of opiates and tranquilizers dispensed. She received only pain
18 and anxiety medication from Dr. Diaz, despite him not being a pain specialist. Patient MM
19 received multiple Oxycodone 30 mg prescriptions on or around the same time from Dr. Diaz
20 which she had dispensed at multiple pharmacies. She also received multiple Oxycontin 80 mg
21 prescriptions on or around the same time from Dr. Diaz which she had dispensed at multiple
22 pharmacies, including at Respondent L M Caldwell Pharmacist-Pueblo Street. Patient MM also
23 received Suboxone, prior to and while going to Respondent L M Caldwell Pharmacist-Pueblo
24 Street. Patient MM did not get any pain or anxiety prescriptions dispensed at LM Caldwell
25 Pharmacist- Pueblo Street after Dr. Diaz. Patient MM received only pain and anxiety medication
26 from Dr. Diaz, despite him not being a pain specialist. Patient MM paid \$1,585.80 cash for
27 Oxycontin 60 mg on July 4, 2010;

28

1 k. Patient SP went to 6 prescribers in Santa Barbara and 7 pharmacies from January 1,
2 2009 to April 9, 2013. She went to pharmacies in Lompoc, Santa Barbara, and Goleta. She lived
3 in Santa Barbara and paid for her medication through insurance. Review of CURES showed
4 therapy duplication based on the number of opiates and tranquilizers dispensed. Patient SP
5 received mostly pain and anxiety medication from Dr. Diaz, despite him not being a pain
6 specialist. Respondent L M Caldwell Pharmacist-Pueblo Street dispensed Prescription No. 33143
7 for Oxycodone IR (1 Tablet, twice daily #60) for a 30 day supply on July 18, 2011 and then again
8 on July 28, 2011 (Prescription No. 33176, 1-3 tablets every 4-6 hours #240.) Patient SP also
9 received therapy duplication in the form of Diazepam and Alprazolam and HC/AP and
10 HC/Ibuprofen from Respondent L M Caldwell Pharmacist- Pueblo Street. Patient SP continued
11 to get one pain medication dispensed at Respondent L M Caldwell Pharmacist- Pueblo Street
12 after Dr. Diaz. The number of pain drugs prescribed by other prescribers was reduced. Patient
13 SP was placed on Suboxone and did not have significant pain or anxiety after Dr. Diaz;

14 l. Patient VS went to 3 prescribers and 6 pharmacies from January 1, 2009 to April 8,
15 2013. She went to prescribers in Santa Barbara, Lompoc and Goleta and went to pharmacies in
16 Lompoc, Santa Barbara, and Santa Maria. She lived in Lompoc (same address as Patient MM)
17 and traveled 55.81 miles to Dr. Diaz's office and lived 53.28 miles from Respondent L M
18 Caldwell Pharmacist- Pueblo Street. Patient VS paid cash for her prescriptions when insurance
19 did not cover the cost of medication. Patient VS paid over \$250.00 for Oxycodone and \$220.00
20 Hydromorphone. Review of CURES showed therapy duplication based on the number of opiates
21 and tranquilizers dispensed. Patient VS received mostly pain and anxiety medication from Dr.
22 Diaz, despite him not being a pain specialist. Respondent L M Caldwell Pharmacist- Pueblo
23 Street dispensed Prescription Nos. 33225, 033221, 33220, 33223 and 33222 with a written date
24 that was not in the prescriber's handwriting. Patient VS received Hydromorphone 4 mg and 8 mg
25 at or around the same time prescribed by Dr. Diaz which he had dispensed sometimes at the same
26 pharmacy, including Respondent L M Caldwell Pharmacist- Pueblo Street. Patient VS did not get
27 any pain or anxiety medication dispensed at LM Caldwell Pharmacist- Pueblo Street after
28

1 September 14, 2011 and did not have any significant pain or anxiety history after Dr. Diaz was
2 investigated.

3 m. Patient MS went to 7 prescribers and 12 pharmacies from January 1, 2009 to April 9,
4 2013. She went to prescribers in Santa Barbara, Solvang, and Goleta and to pharmacies in
5 Lompoc, Santa Barbara, Oxnard, Santa Ynez Santa Maria and Goleta. She lived in Santa Barbara
6 and paid cash for her medication. She paid approximately \$350.00 for Hydromorphone, \$103 for
7 Methadone, \$130.00 for Alprazolam, \$218.00 for HC/AP, and \$200.00 for Oxycodone. Review
8 of CURES showed therapy duplication based on the number of opiates and tranquilizers
9 dispensed. Patient MS went to multiple pharmacies and mainly went to Dr. Diaz. Patient MS
10 received mostly pain and anxiety medication from Dr. Diaz, despite him not being a pain
11 specialist. Patient MS received multiple prescriptions for AC/AP 10/325 mg from Dr. Diaz
12 which she dispensed at multiple pharmacies. She received 600-840 tablets of HC/AP within 30
13 days and received 7,800 mg per day to 9,750 mg per day of Acetaminophen. The practice of
14 Patient MS receiving multiple prescriptions dispensed at multiple pharmacies began in March of
15 2010 and continued monthly until November of 2011. Patient MS received multiple prescriptions
16 for Alprazolam 2 mg from Dr. Diaz which she dispensed at multiple pharmacies. MS received
17 240-360 tablets of Alprazolam within 30 days. Patient MS had a couple of pain prescriptions
18 dispensed at L M Caldwell Pharmacist-Pueblo Street after Dr. Diaz and the quantities and therapy
19 duplications prescribed by other prescribers were reduced;

20 n. Patient RS went to 2 prescribers in Santa Barbara and 6 pharmacies in Santa Barbara
21 and Goleta from January 1, 2009 to April 9, 2013. She lived in Santa Barbara and paid cash for
22 her medication. She paid approximately \$225.00 for Hydromorphone, \$175.00 for HC/AP, and
23 \$107 for Alprazolam. Review of CURES showed therapy duplication based on the number of
24 opiates and tranquilizers dispensed. Patient MS went to multiple pharmacies and mainly went to
25 Dr. Diaz. Patient MS received mostly pain and anxiety medication from Dr. Diaz, despite him
26 not being a pain specialist. Patient RS had no significant pain or anxiety history prior to going to
27 Dr. Diaz. However, Dr. Diaz began by prescribing him Methadone 10 mg, Hydromorphone 8 mg,
28 HC/AP 10/325 mg and Alprazolam 2 mg. Patient RS received multiple prescriptions for HC/AP

1 10/325 mg from Dr. Diaz which he dispensed at multiple pharmacies. Patient RS received 480
2 tablets of HC/AP within 30 days and received 5,200 mg per day of Acetaminophen. The practice
3 of Patient RS getting multiple prescriptions dispensed at multiple pharmacies began in August of
4 2011 and continued monthly until December of 2011. Patient RS did not get any pain or anxiety
5 prescriptions dispensed at LM Caldwell Pharmacist – Pueblo Street after Dr. Diaz. Respondent L
6 M Caldwell Pharmacist- Pueblo Street dispensed Prescription No. 336005 for Buprenorphine,
7 used for treatment of narcotic addiction on December 1, 2011, prescribed by Dr. Diaz.

8 75. L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi did not know the
9 diagnosis for patients GA, RB, CB, CC, JF, CG, GJ, IJ, ML, KM, MM, SP, VS, MS, RS, and
10 knew that Dr. Diaz was a family practitioner and not a pain management physician. Also, L M
11 Caldwell Pharmacist-Pueblo Street and Respondent Caldwell failed to maintain records or files
12 on drug therapy for these patients, and failed to check data in CURES.

13 76. When reviewing the records for patients GA, RB, CB, CC, JF, CG, GJ, IJ, ML, KM,
14 MM, SP, VS, MS, and RS, it was noted that eight out of these fifteen patients lived outside Dr.
15 Diaz's trading area and five out of nine lived outside of LM Caldwell Pharmacist-Pueblo Street
16 normal trading area. The range of distance travelled for the selected patients was between 6.97
17 miles for the shortest to 111.97 for the longest. The average distance traveled by the patient was
18 35.26 miles and the total distance these patients travelled to obtain controlled substances was
19 excessive. Five of the fifteen patient home addresses were not recognized by Mapquest. In
20 addition seven of the fifteen patients had the same address. Eight of the fifteen patients reviewed
21 lived outside of Dr. Diaz's normal trading area and five of fifteen lived outside of L M Caldwell
22 Pharmacist-Pueblo Street normal trading area.

23 77. Most of the patients paid cash, including when the medication was not covered
24 by their insurance or to get early refills. Some patients had insurance/Medicaid, however, were
25 willing to pay a large sum of cash for controlled substances which were not covered by the plans,
26 including those on Medicaid.

27 ///

28

78. There was excessive furnishing of controlled substances prescribed by Dr. Diaz. The dispensing ratio of prescriptions by Dr. Diaz by L M Caldwell Pharmacist -Pueblo Street and Respondent Yahyavi was greatly unbalanced when compared to other neighboring pharmacies, including the following three pharmacies: Federal Drugs PHY37078 (located 1.83 miles from L M Caldwell Pharmacist-Pueblo Street), Rite-Aid #5785 PHY 42255 (located 1.72 miles from L M Caldwell Pharmacist-Pueblo Street), and CVS#9392 PHY 494473 (located 1.46 miles from L M Caldwell Pharmacist-Pueblo Street). L M Caldwell Pharmacist-Pueblo Street filled tens of thousands more controlled substances prescribed by Dr. Diaz when compared to neighboring pharmacies for the time period specified of January 1, 2011 through December 5, 2012. The CURES data for the L M Caldwell Pharmacist- Pueblo Street and three surrounding pharmacies, for example, was as follows:

Pharmacy	Total controlled substances dispensed between 1/1/2011-12/5/2012	Total Dr. Diaz's RX from 1/1/2011-12/5/2012	Total quantity for Dr. Diaz's RX from 1/1/2011-12/5/2012	% of total controlled substance RX dispensed for Dr. Diaz
Respondent LM Caldwell Pharmacist – Pueblo Street	11,215	1,418	215,186	12.64%
Federal Drugs PHY 37078 (1.92 miles from LM Caldwell)	18,282	0	0	0%
Rite-Aid #5785 PHY 42255 (.065 miles from LM Caldwell Pharmacist)	3,584	0	0	0%
CVS # 9392 PHY 49473 (.41 miles from LM Caldwell)	13,365	44	6,599	.33%

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1 81. A review of Respondent L M Caldwell Pharmacists- Pueblo Street's profile for
 2 Patient AM revealed that Patient AM received the following controlled substances at LM
 3 Caldwell Pharmacists-Pueblo Street:

RX Date	RX #	Drug	Prescriber
8/23/2010	320263	Hydromorphone 8 mg 2 tablets every 6 hours as needed for pain #240	Dr. Diaz
	230234	Oxycodone 30 mg 2 tablet every 6 hours as needed for pain. #240	
9/20/2010	321036	Hydromorphone 8 mg 2 tablets every 4-6 hours as needed for pain #240	Dr. Diaz
		Oxycodone 30 mg 2 tablet every 4-6 hours as needed for pain. #240	
10/14/2010	322230	Oxycodone 30 mg 2 tablet every 2-4 hours #260	Dr. Diaz
	322231	Hydromorphone 8 mg 2 tablets every 2-4 hours #260	
	322232	Methadone 10 mg 2 pills every 12 hours #120	
11/11/2010	323197	Hydromorphone 8 mg 2 tablets every 4-6 hours #260	Dr. Diaz
	323198	Oxycodone 30 mg 2 tablet every 4-6 hours #260	

22 82. A review of Respondent L M Caldwell Pharmacists- Pueblo Street's profile for
 23 Patient AM and CURES records also revealed that Patient AM saw 4 prescribers and went to 8
 24 pharmacies from January 1, 2009 to April 8, 2013. Patient AM saw prescribers in Santa Barbara,
 25 Solvang, and Shell Beach. Patient AM received only pain medication from Dr. Diaz, despite him
 26 not being a pain specialist. Patient AM traveled over 70 miles from home in Solvang to obtain
 27 the prescriptions from Dr. Diaz and then to LM Caldwell Pharmacists-Pueblo Street to have the
 28 prescriptions dispensed. Patient AM paid cash for his medication.

1 83. LM Caldwell Pharmacists-Pueblo Street and Respondent Yahyavi dispensed 9
2 prescriptions for AM. However, if they would have checked CURES data, they would have been
3 able to determine there was unusual prescribing patterns for Dr. Diaz and that Patient AM was
4 going to multiple pharmacies. Patient AM, for example, went to 2 separate pharmacies on the
5 same day to get Oxycodone and Hydromorphone. Since Respondent Yahyavi knew Dr. Diaz as
6 the "Candy Man," he should have questioned the legitimacy of his prescriptions.

7 84. From January 1, 2010 to January 1, 2014, Respondent Yahyavi, failed to exercise best
8 professional judgment while dispensing controlled substance prescriptions for Patient AM
9 prescribed by Dr. Diaz. Looking at the totality of the factors such as repetitive prescribing
10 patterns for highly abused controlled substances, the location of prescriber's practice in relation to
11 the location of AM's residence, and patient's payment methods. Respondent Yahyavi also failed
12 to appropriately scrutinize patients' drug therapy with readily available tools such as CURES
13 reports and its own pharmacy records. The result of this negligence was the dispensing of
14 controlled substances for AM who habitually engaged in doctor shopping and multiple pharmacy
15 activity. Respondent Yahyavi should have questioned the legitimacy of the prescriptions it and
16 Respondent L M Caldwell Pharmacists-Pueblo Street dispensed to Patient AM.

17 **Conviction and Medical Board Disciplinary Action**

18 85. On April 29, 2011, the Board received an arrest report from the California
19 Department of Justice for Pharmacy Technician DLM who had been arrested on allegations that
20 he stole Oxycontin from his employer Respondent L M Caldwell Pharmacist-State Street and sold
21 the drugs to an undercover detective. In May of 2011, Pharmacy Technician DLM, following a
22 plea, was convicted of the sale of a controlled substance Oxycontin under Health and Safety Code
23 section 11352, subdivision (a).

24 86. On January 5, 2012, the Board received notification that Dr. Diaz was allegedly
25 linked to a string of deaths involving prescriptions drugs and had been arrested for allegedly
26 prescribing an excessive amount of painkillers to his patients. On May 13, 2014, the California
27 Medical Board revoked Dr. Diaz's license as a general practitioner and his specialty in Geriatrics
28

1 and Pathology for gross negligence in the care and treatment of a patient, prescribing excessive
2 narcotic medications to patients, and failing to maintain adequate and accurate records.

3 **Board Inspections and Audits**

4 87. On July 13, 2011, January 1, 2013, and January 15, 2013, the Board inspected
5 Respondent L M Caldwell Pharmacist-State Street. The Board also conducted audits of
6 Respondent L M Caldwell Pharmacist-State Street from 2009 to January 2013.

7 88. On January 16, 2013, the Board inspected Respondent L M Caldwell Pharmacist-
8 Pueblo Street. During the inspection, Respondent Yahyavi admitted to the inspector that he
9 knew Dr. Diaz as the "Candy Man." The Board also conducted audits of Respondent L M
10 Caldwell Pharmacist-Pueblo Street from 2009 to January 2013.

11 89. On April 8, 2013, the Board issued a written Notice of Noncompliance to Respondent
12 L M Caldwell Pharmacist-State Street and Respondent Caldwell. The Board also issued a written
13 Notice of Noncompliance to Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent
14 Yahyani.

15 90. On July 31, 2013, the Board issued a written Notice of Noncompliance to Respondent
16 L M Caldwell Pharmacists-Pueblo Street and Respondent Yahyavi.

17 91. On August 7, 2013, the Board issued another written Notice of Noncompliance to
18 Respondent L M Caldwell Pharmacists-State Street and Respondent Caldwell.

19 **FIRST CAUSE FOR DISCIPLINE**

20 **(Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacy)**

21 **(Against Respondent L M Caldwell Pharmacist -State Street)**

22 92. Respondent L M Caldwell Pharmacist-State Street is subject to discipline under
23 section 4301, subsection (o) of the Code, and/or California Code of Regulations, title 16, section
24 1714, subsection (b), for failure to maintain its facilities, space, fixtures, and equipment so that
25 drugs are safely and properly prepared, maintained, secured and distributed. The circumstances
26 are that between November 15, 2009 to July 13, 2011, Respondent L M Caldwell Pharmacist-
27 State Street could not account for the loss of 5,360 tablets of Hydromorphone 8 mg. Between
28 August 6, 2011 to January 15, 2013, Respondent L M Caldwell Pharmacist-State Street could not

1 account for the loss of 8,800 tablets of Hydromorphone 8 mg and the loss of 605 tablets of
2 Oxycodone 30 mg. Complainant refers to, and by this reference, incorporates the allegations set
3 forth above in paragraphs 45 through 46, as though set forth fully.

4 **SECOND CAUSE FOR DISCIPLINE**

5 **(Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacist)**

6 **(Against Respondent Caldwell)**

7 93. Respondent Caldwell is subject to discipline under section 4301, subdivision (o), of
8 the Code, and California Code of Regulations, title 16, section 1714, subdivision (d), for failure to
9 maintain the security of the prescription department, including provisions for effective control
10 against theft or diversion of dangerous drugs and devices, and records for such drugs and devices
11 and to ensure that possession of a key to the pharmacy where dangerous drugs and controlled
12 substances are stored is restricted to pharmacists. The circumstances are that between November
13 15, 2009 to July 13, 2011, Respondent Caldwell could not account for the loss of 5,360 tablets of
14 Hydromorphone 8 mg. Between August 6, 2011 to January 15, 2013, Respondent Caldwell could
15 not account for the loss of 8,800 tablets of Hydromorphone 8 mg and the loss of 605 tablets of
16 Oxycodone 30 mg. Complainant refers to, and by this reference, incorporates the allegations set
17 forth above in paragraphs 45 through 46, as though set forth fully.

18 **THIRD CAUSE FOR DISCIPLINE**

19 **(Failure to Maintain Records of Acquisition and Disposition of Dangerous Drugs)**

20 **(Against L M Caldwell Pharmacist- State Street, Respondent L M Caldwell Pharmacist-**

21 **Pueblo Street, Respondent Caldwell, and Respondent Yahyavi)**

22 94. Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell
23 Pharmacist-Pueblo Street, Respondent Caldwell and Respondent Yahyavi, are each and severally
24 subject to disciplinary action under section 4081, subdivision (a), and section 4105, subdivision
25 (a) of the Code, for failure to maintain all records of sale, acquisition or disposition of dangerous
26 drugs at all times open to inspection and preserved for at least three years from the date of
27 making. The circumstances are as follows:
28

1 a. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could
2 not account for the records of acquisition and disposition and the current inventory. Between
3 November 15, 2009 and July 13, 2011, Respondent L M Caldwell Pharmacist- State Street and
4 Respondent Caldwell could not account for an inventory overage (disposition greater than
5 acquisition) of 55,370 tablets of HC/AP 10/325 mg and 165 tablets of Oxycodone SR 80 mg.
6 Between August 6, 2011 and January 15, 2013, Respondent L M Caldwell Pharmacist-State
7 Street and Respondent Caldwell could not account for an inventory overage of 78,746 tablets of
8 HC/AP 10/325 mg. Complainant refers to, and by this reference, incorporates the allegations set
9 forth above in paragraphs 42 through 43, as though set forth fully.

10 b. Between January 5, 2010 and January 15, 2013, Respondent L M Caldwell
11 Pharmacist-State Street and Respondent Caldwell could not account for prescription hardcopies
12 for Prescriptions Nos. 793824, 793825, 793826, 789177, 789188, 793189, 793190, 805552,
13 782075, 792283, 793432, 793184, 791387, 797610, 787609, 790594, 790595, 790597, 795658,
14 804361, 792346, 793090, 795652, 776675, 773787, 779441, 780927, 790980, 792044, 792920,
15 792935 and 792928. Complainant refers to, and by this reference, incorporates the allegations set
16 forth above in paragraphs 44, as though set forth fully.

17 c. Between December 18, 2010 and December 17, 2012, Respondent L M Caldwell
18 Pharmacist-Pueblo Street and Respondent Yahyavi could not account for an inventory overage of
19 53,811 tablets of HC/AP 10/325 mg. Complainant refers to, and by this reference, incorporates
20 the allegations set forth above in paragraph 68, as though set forth fully.

21 c. On January 16, 2013, LM Caldwell Pharmacist-Pueblo Street and Respondent
22 Yahyavi were unable to provide the original prescription documents for RX # 327435, 334405, ,
23 317892, 317893, 317894, 330297, 323526, 324203, 325803, 325881, 312027, 316180, 315861,
24 322717, 322718, 319209, 322715, 330610, 333178, 334336, 318220, 331648, 322460, 332461,
25 326892, 327949, 332102, and 336005. Complainant refers to, and by this reference, incorporates
26 the allegations set forth above in paragraph 69, as though set forth fully.

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1 **FOURTH CAUSE FOR DISCIPLINE**

2 **(Failure to Provide Drug Sales and Purchase Records After Furnishing Dangerous Drugs)**
3 **(Against L M Caldwell Pharmacist-State Street, Respondent L M Caldwell Pharmacist-**
4 **Pueblo Street, Respondent Caldwell and Respondent Yahyavi)**

5 95. Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell
6 Pharmacist-Pueblo Street, Respondent Caldwell and Respondent Yahyavi, are each and severally
7 subject to disciplinary action under section 4059, subdivision (b), of the Code, for furnishing a
8 dangerous drug or dangerous device to each other without sales and purchase records that
9 correctly give the date, names and addresses of the supplier and buyer, the drug or device and the
10 quantity. The circumstances are as follows:

11 a. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell
12 Pharmacist-State Street and Respondent Caldwell sold HC/AP 10/325 mg to Respondent
13 Caldwell Pharmacist- Pueblo Street without adequate sales records. Complainant refers to, and
14 by this reference, incorporates the allegations set forth above in paragraph 47, as though set forth
15 fully.

16 b. Between July 23, 2010 and December 28, 2012, L M Caldwell Pharmacist-Pueblo
17 Street and Respondent Yahyavi purchased HC/AP 10/325 mg from Caldwell Pharmacist-State
18 Street without adequate purchase records. Complainant refers to, and by this reference,
19 incorporates the allegations set forth above in paragraph 70, as though set forth fully.

20 **FIFTH CAUSE FOR DISCIPLINE**

21 **(Unprofessional Conduct: Failure to Exercise Corresponding Responsibility)**
22 **(Against L M Caldwell Pharmacist- State Street, Respondent L M Caldwell Pharmacist-**
23 **Pueblo Street, Respondent Caldwell and Respondent Yahyavi)**

24 96. Respondent L M Caldwell Pharmacist-State Street, Respondent L M Caldwell
25 Pharmacist- Pueblo Street, Respondent Caldwell and Respondent Yahyavi are each and severally
26 subject to disciplinary action under section 4301, subdivisions (d) and (j), of the Code, Health and
27 Safety code section 11153, subdivision (a), and California Code of Regulations, title 16, section
28 1761, subdivisions (a) and (b), for excessive furnishing of controlled substances with an

1 established history of a high potential for abuse despite multiple cues of irregularity and
2 uncertainty related to patient and prescriber factors, and in failing to comply with their
3 corresponding responsibility to ensure that controlled substances are dispensed for a legitimate
4 medical purpose:

5 a. Specifically, between January 1, 2011 and December 5, 2012, Respondent L M
6 Caldwell Pharmacist- State Street, and Respondent Caldwell dispensed 1,492 controlled
7 substance prescriptions written by Dr. Julio Diaz with disregard to the following factors: distance
8 from the pharmacy to Dr. Diaz's office, distance from the pharmacy to each patient's home,
9 percentage of cash patients specific to listed prescribers, pattern of patients willing to pay cash for
10 highly expensive prescriptions, and same or similar prescribing patterns for individual patients
11 from alleged pain specialists. Respondent L M Caldwell Pharmacist-State Street, and Respondent
12 Caldwell failed to appropriately scrutinize patients' drug therapy with readily available tools such
13 as CURES reports and its own pharmacy records, including to Patients VA, BA, KB, CD, LD,
14 TF, JH, MM, AM, SM, SS, JS, NS, VS and CW. From January 1, 2010 to January 1, 2013, LM
15 Caldwell Pharmacist-State Street and Respondent Caldwell failed to exercise their corresponding
16 responsibility with regard to Patient JJ. Complainant refers to, and by this reference, incorporates
17 the allegations set forth above in paragraphs 48 through 66 as though set forth fully.

18 b. Specifically, between January 1, 2011 and December 7, 2012, Respondent L M
19 Caldwell Pharmacist- Pueblo Street, and Respondent Yahyavi dispensed 1,418 controlled
20 substance prescriptions written by Dr. Julio Diaz with disregard to the following factors: distance
21 from the pharmacy to Dr. Diaz's office, distance from the pharmacy to each patient's home,
22 percentage of cash patients specific to listed prescribers, pattern of patients willing to pay cash for
23 highly expensive prescriptions, and same or similar prescribing patterns for individual patients
24 from alleged pain specialists. Respondent L M Caldwell Pharmacist-Pueblo Street, and
25 Respondent Yahyavi failed to appropriately scrutinize patients' drug therapy with readily
26 available tools such as CURES reports and its own pharmacy records, including to Patients GA,
27 RB, CB, CC, JF, CG, IJ, ML, KM, MM, SP, VS, MS and RS. From January 1, 2010 to January
28 1, 2014, LM Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi failed to exercise their

1 corresponding responsibility with regard to Patient AM. Complainant refers to, and by this
2 reference, incorporates the allegations set forth above in paragraphs 73 through 84, as though set
3 forth fully.

4 **SIXTH CAUSE FOR DISCIPLINE**

5 **(Unprofessional Conduct: Dispensing Prescriptions Which**
6 **Contains Significant Error, Omission, Irregularity, Uncertainty, Ambiguity or Alteration)**
7 **(Against L M Caldwell Pharmacist-State Street and Respondent Caldwell)**

8 97. Respondent L M Caldwell Pharmacist- State Street, and Respondent Caldwell are
9 each and severally subject to disciplinary action under section 4301, subdivision (o), of the Code,
10 and California Code of Regulations section 1761, subdivisions (a) and (b), for dispensing a
11 prescription which contained a significant error, omission, irregularity, uncertainty, ambiguity, or
12 alteration, for failing to contact the prescriber to obtain information to validate the prescription,
13 and/or for dispensing a controlled substance knowing or having the objective reason to know that
14 the prescription was not issued for a legitimate purpose, even after conferring with the prescriber.
15 The circumstances are as follows:

16 a. On March 22, 2011, Respondent L M Caldwell Pharmacist-State Street and
17 Respondent Caldwell dispensed Prescription No. 784841 for Morphine Sulfate 10 mg/ml solution
18 that was written with no quantity on the prescription with the quantity box for "151 & over"
19 marked. Respondent L M Caldwell Pharmacist- State Street and Respondent Caldwell
20 dispensed 360 mls of Morphine Sulfate solutions with no documentation on the prescription
21 indicating that the prescribing physician, Dr. Diaz, was contacted to clarify the quantity.
22 Complainant refers to, and by this reference, incorporates the allegations set forth above in
23 paragraph 55, subparagraph (d), as though set forth fully.

24 b. On May 20, 2011, Respondent L M Caldwell Pharmacist-State Street and Respondent
25 Caldwell dispensed Prescription No. 784839 for Fentanyl 100 mcg/hour with directions to apply
26 every 48 hours. The manufacturer's direction was to change the patch every 72 hours.
27 Complainant refers to, and by this reference, incorporates the allegations set forth above in
28 paragraph 55, subparagraph (e), as though set forth fully.

1 **SEVENTH CAUSE FOR DISCIPLINE**

2 **(Exceeding the Day Supply for Controlled Substance Refills)**

3 **(Against L M Caldwell Pharmacist-State Street and Respondent Caldwell)**

4 98. Respondent L M Caldwell Pharmacist-State Street, and Respondent Caldwell are
5 each and severally subject to disciplinary action under Health and Safety Code section 11200,
6 subdivision (b) for refilling a prescription for Schedule II or IV substance more than five times
7 and/or in an amount, for all refills of that prescription taken together, exceeding a 120-day supply.

8 The circumstances are as follows:

9 a. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell
10 dispensed Prescription No. 782251 for Alprazolam, a Schedule IV controlled substance, on
11 March 25, 2011 for a 30 day supply. They then refilled Prescription No. 782251 five times on
12 April 22, 2011, May 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011, for a total of
13 five (5) refills for a total of a 150-day supply. Complainant refers to, and by this reference,
14 incorporates the allegations set forth above in paragraph 56, subparagraph (a), as though set forth
15 fully.

16 b. Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell
17 dispensed Prescription No. 782250 for Diazepam, a Schedule IV controlled substance, on March
18 25, 2011 for a 30 day supply. They then refilled Prescription No. 782250 on April 22, 2011, May
19 18, 2011, June 16, 2011, July 18, 2011 and August 17, 2011, for a total of five (5) refills for a
20 total of a 150-day supply. Complainant refers to, and by this reference, incorporates the
21 allegations set forth above in paragraph 56, subparagraph (b), as though set forth fully.

22 **EIGHTH CAUSE FOR DISCIPLINE**

23 **(Unprofessional Conduct: Variation from Prescription)**

24 **(Against L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi)**

25 99. Respondent L M Caldwell Pharmacist-Pueblo Street, and Respondent Yahyavi are
26 each and severally subject to disciplinary action under section 4301, subdivision (o), of the Code,
27 and California Code of Regulations section 1716, when they deviated from the requirements of a
28

1 prescription without the prior consent of the prescriber. Specifically, between January 1, 2010
2 and January 15, 2013, they dispensed the following prescriptions incorrectly:

3 (1) Prescription No. 321310, was for Oxycodone 30 mg 1-2 every 6 hour as needed for
4 pain. Respondents dispensed it as 1 tablet four times daily as needed for pain;

5 (2) Prescription No. 321312, was for Xanax mg 1-2 times daily for panic. Respondents
6 dispensed it as 1 tablet four times daily;

7 (3) Prescription No. 325038, was for 30 mg 1-2 HC/AP 7.5/750 mg. Prescriber wrote 1
8 tablet every 6 hours as needed for pain and Respondents dispensed it as 1 tablet every 4-6 hours
9 as needed for pain;

10 (4) Prescription No. 331728, was for Dilaudid 8 mg, 1 every 6 hours #120. Respondents
11 dispensed Hydromorphone 8 mg, 1-2 tablets every 6 hours;

12 (5) Prescription No. 332908, was for Methadone 10 mg 7 tablets every 12 hours #400.
13 Respondents dispensed it as 6 tablets every 12 hours;

14 (6) Prescription No. 335645, was for Oxycodone IR 30 mg 1 tablet every 4-6 hour.
15 Respondents dispensed Oxycodone IR 30 mg 1 tablet every 6 hours.

16 Complainant refers to, and by this reference, incorporates the allegations set forth above in
17 paragraph 71, subdivisions (a) through (f) as though set forth fully.

18 **NINTH CAUSE FOR DISCIPLINE**

19 **(Unprofessional Conduct: Dispensing Balance of**
20 **Schedule II Prescriptions Beyond 72 hours)**

21 **(Against L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi)**

22 100. Respondent L M Caldwell Pharmacist-Pueblo Street, and Respondent Yahyavi are
23 each and severally liable to disciplinary action under section 4301, subdivision (o), of the Code,
24 and California Code of Regulations section 1745, subdivision (d), as it related to Code of Federal
25 Regulations 1306.13, subdivision (a) as follows:

26 a. Review of prescriptions, from January 1, 2010 to January 15, 2013, revealed that
27 Respondent L M Caldwell Pharmacist-Pueblo Street and Respondent Yahyavi partially filled
28 prescriptions for controlled substances listed in Schedule II and then dispensed the balance of the

1 prescription after the 72 hour period allowed for dispensing the balance of prescriptions.
2 Specifically between January 1, 2010 to January 15, 2013, Respondents dispensed Prescription
3 Nos. 329771, 331396, 332230, and 33265, then dispensed the balance of the prescriptions after 72
4 hours. Complainant refers to, and by this reference, incorporates the allegations set forth above
5 in paragraph 72 as though set forth fully.

6 DISCIPLINE CONSIDERATIONS

7 101. To determine the degree of discipline, if any, to be imposed on Respondent L M
8 Caldwell Pharmacists-Pueblo Street, Complainant alleges that on or about February 27, 2007, in a
9 prior action, the Board of Pharmacy issued Citation Number CI 2006-32134 against Respondent
10 L M Caldwell Pharmacist-Pueblo Street for violating California Code of Regulations, title 16,
11 section 1716. A copy of the citation is attached as Exhibit A. That Citation is now final and is
12 incorporated as if fully set forth. Complainant further alleges that on or about November 14,
13 2008, in a prior action, the Board of Pharmacy issued Citation Number CI 2007-35415 against
14 Respondent L M Caldwell Pharmacists-Pueblo Street for violating California Code of
15 Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit B. That Citation
16 is now final and is incorporated as if fully set forth.

17 102. To determine the degree of discipline, if any, to be imposed on Respondent Yahyavi,
18 Complainant alleges that on or about February 27, 2007, in a prior action, the Board of Pharmacy
19 issued Citation Number CI 2006-32988 against Respondent Yahyavi and ordered him to pay fines
20 in the amount of \$ 250.00 for violating California Code of Regulations, title 16, section 1716. A
21 copy of the citation is attached as Exhibit C. That Citation is now final and is incorporated as if
22 fully set forth. Complainant further alleges that on or about November 14, 2008, in a prior action,
23 the Board of Pharmacy issued Citation Number CI 2008-37974 against Respondent Yahyavi and
24 ordered him to pay fines in the amount of \$750.00 for violating California Code of Regulations,
25 title 16, section 1716. A copy of the citation is attached as Exhibit D. That Citation is now final
26 and is incorporated as if fully set forth.

27 ///

28

1 103. To determine the degree of discipline, if any, to be imposed on Respondent L M.
2 Caldwell Pharmacists- State Street, Complainant alleges that on or about July 23, 2013, in a prior
3 action, the Board of Pharmacy issued Citation Number CI 2011 49544 against Respondent L M.
4 Caldwell Pharmacists- State Street for violating California Code of Regulations, title 16, section
5 1716 and section 1711, subdivisions (d) and (e). A copy of the citation is attached as Exhibit E.
6 That Citation is now final and is incorporated as if fully set forth herein.

7 104. To determine the degree of discipline, if any, to be imposed on Respondent Caldwell,
8 Complainant alleges that on or about July 23, 2013, in a prior action, the Board of Pharmacy
9 issued Citation Number CI 2013 57599 against Respondent Caldwell for violating California
10 Code of Regulations, title 16, section 1716 and section 1711, subdivisions (d) and (e). A copy of
11 the citation is attached as Exhibit F. That Citation is now final and is incorporated as if fully set
12 forth herein. Respondent Caldwell, Complainant alleges that on or about February 29, 2012, in a
13 prior action, the Board of Pharmacy issued Citation Number CI 2010 48187 against Respondent
14 Caldwell for violating California Code of Regulations, title 16, section 1732.5 and Business and
15 Professions Code 4231, subdivision (d) and 4301, subdivision (g). A copy of the citation is
16 attached as Exhibit G. That Citation is now final and is incorporated as if fully set forth herein.

17 **PRAYER**

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

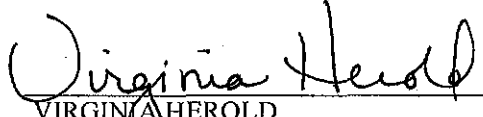
- 20 1. Revoking or suspending Pharmacy Permit Number PHY 30911, issued to Peter
21 Caldwell to do business as L M Caldwell Pharmacist;
- 22 2. Revoking or suspending Pharmacy Permit Number PHY 30912, issued to Peter
23 Caldwell to do business as L M Caldwell Pharmacist;
- 24 3. Revoking or suspending Pharmacist License Number 25356, issued to Peter Craig
25 Caldwell;
- 26 4. Revoking or suspending Pharmacist License Number 30041, issued to Abdul
27 Yahyavi;
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6. Ordering L M Caldwell Pharmacist (PHY 30911), L M Caldwell Pharmacist (PHY 30912), Peter Craig Caldwell, and Abdul Yahyavi to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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

DATED: 8/13/15



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

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7 *Attorneys for Complainant*

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

10
11 In the Matter of the Accusation Against:

Case No. 4867

12 **PETER CRAIG CALDWELL doing**
13 **business as L M CALDWELL**
PHARMACIST
14 **1509 State St.**
Santa Barbara, CA 93101
15 **Pharmacy Permit No. PHY 30911**

A C C U S A T I O N

16 **PETER CRAIG CALDWELL doing**
17 **business as L M CALDWELL**
PHARMACIST
18 **235 West Pueblo St.**
Santa Barbara, CA 93105
19 **Pharmacy Permit No. PHY 30912**

20 **PETER CRAIG CALDWELL**
21 **1509 State St.**
Santa Barbara, CA 93101
22 **Pharmacist License No. RPH 25356**

23 **ABDUL YAHYAVI**
24 **1624 La Coronilla Drive.**
Santa Barbara, CA 93109
25 **Pharmacist License No. RPH 30041**

26 Respondent.

27 ///

28

1 Complainant alleges:

2 PARTIES

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

5 2. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit
6 Number PHY 30911 to Peter Caldwell to do business as L M Caldwell Pharmacist located at
7 1509 State Street, Santa Barbara, CA 93101 (Respondent L M Caldwell Pharmacist-State Street).
8 The Pharmacy Permit was in full force and effect at all times relevant to the charges brought
9 herein and will expire on December 1, 2013, unless renewed. Peter C. Caldwell has been the
10 individual licensed owner of Respondent State Street Pharmacy since December 13, 1984. Peter
11 C. Caldwell has been the Pharmacist-In-Charge of Respondent Pueblo Street Pharmacy since
12 December 1, 1984.

13 3. On or about December 1, 1984, the Board of Pharmacy issued Pharmacy Permit
14 Number PHY 30912 to Peter Caldwell to do business as L M Caldwell Pharmacist located at 235
15 West Pueblo Street, Santa Barbara, CA 93105 (Respondent L M Caldwell Pharmacist- Pueblo
16 Street). The Pharmacy Permit was in full force and effect at all times relevant to the charges
17 brought herein and will expire on December 1, 2013, unless renewed. Abdul Yahyavi has been
18 the Pharmacist-In-Charge of Respondent Pueblo Street Pharmacy since December 1, 1984.

19 4. On or about January 6, 1968, the Board of Pharmacy issued Pharmacist Number
20 25356 to Peter Craig Caldwell (Respondent Caldwell). The Pharmacist License was in full force
21 and effect at all times relevant to the charges brought herein and will expire on May 31, 2015,
22 unless renewed.

23 5. On or about December 10, 1975, the Board of Pharmacy issued Pharmacist Number
24 30041 to Abdul Yahyavi (Respondent Yahyavi). The Pharmacist License was in full force and
25 effect at all times relevant to the charges brought herein and will expire on June 30, 2014, unless
26 renewed.

27 ///

JURISDICTION

1
2 6. This Accusation is brought before the Board of Pharmacy (Board), Department of
3 Consumer Affairs, under the authority of the following laws. All section references are to the
4 Business and Professions Code unless otherwise indicated.

5 7. Section 118, subdivision (b), of the Code provides that the
6 suspension/expiration/surrender/cancellation of a license shall not deprive the
7 Board/Registrar/Director of jurisdiction to proceed with a disciplinary action during the period
8 within which the license may be renewed, restored, reissued or reinstated.

9 8. Section 4300 of the Code states:

10 (a) Every license issued may be suspended or revoked.

11 (b) The board shall discipline the holder of any license issued by the board, whose
12 default has been entered or whose case has been heard by the board and found guilty,
by any of the following methods:

13 (1) Suspending judgment.

14 (2) Placing him or her upon probation.

15 (3) Suspending his or her right to practice for a period not exceeding on
16 year.

17 (4) Revoking his or her license.

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

20 ...

21 (e) The proceedings under this article shall be conducted in accordance with Chapter
22 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code,
23 except that the propriety of the action is subject to review by the superior court
pursuant to Section 1094.5 of the Code of Civil Procedure."

24 9. Section 4300.1 of the Code states:

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

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

6 (p) Actions or conduct that would have warranted denial of a license.

7 (q) Engaging in any conduct that subverts or attempts to subvert an investigation of
8 the board.

9 ...

10 12. Section 4022 of the Code states

11 Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use
12 in humans or animals, and includes the following:

13 (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without
14 prescription," "Rx only," or words of similar import.

15 (b) Any device that bears the statement: "Caution: federal law restricts this device to
16 sale by or on the order of a _____," "Rx only," or words of similar import, the
17 blank to be filled in with the designation of the practitioner licensed to use or order
18 use of the device.

19 (c) Any other drug or device that by federal or state law can be lawfully dispensed
20 only on prescription or furnished pursuant to Section 4006.

21 13. Section 4051 of the Code states:

22 (a) Except as otherwise provided in this chapter, it is unlawful for any person to
23 manufacture, compound, furnish, sell, or dispense any dangerous drug or dangerous
24 device, or to dispense or compound any prescription pursuant to Section 4040 of a
25 prescriber unless he or she is a pharmacist under this chapter.

26 (b) Notwithstanding any other law, a pharmacist may authorize the initiation of a
27 prescription, pursuant to Section 4052, and otherwise provide clinical advice or
28 information or patient consultation if all of the following conditions are met:

(1) The clinical advice or information or patient consultation is provided to a
health care professional or to a patient.

(2) The pharmacist has access to prescription, patient profile, or other
relevant medical information for purposes of patient and clinical consultation and
advice.

(3) Access to the information described in paragraph (2) is secure from
unauthorized access and use."

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1 14. Section 4077 of the Code states, in pertinent part, that except as provided in
2 subdivisions (b) and (c), of this section, no person shall dispense any dangerous drug upon
3 prescription except in a container correctly labeled with the information required by Section
4 4076.

5 15. Section 4081 of the Code states:

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

17 (b) The owner, officer, and partner of any pharmacy, wholesaler, or veterinary
18 food-animal drug retailer shall be jointly responsible, with the pharmacist-in-charge
19 or representative-in-charge, for maintaining the records and inventory described in
20 this section.

21 (c) The pharmacist-in-charge or representative-in-charge shall not be criminally
22 responsible for acts of the owner, officer, partner, or employee that violate this
23 section and of which the pharmacist-in-charge or representative-in-charge had no
24 knowledge, or in which he or she did not knowingly participate.

25 16. Code section 4126.5, subdivision (a), provides:

26 (a) A pharmacy may furnish dangerous drugs only to the following:

27 ...

28 (4) Another pharmacy or wholesaler to alleviate a temporary shortage of a
dangerous drug that could result in the denial of health care. A pharmacy
furnishing dangerous drugs pursuant to this paragraph may only furnish a
quantity sufficient to alleviate the temporary shortage.

(5) A patient or to another pharmacy pursuant to a prescription or as otherwise
authorized by law.

...

(7) To another pharmacy under common control.

///

1 17. Section 4328 of the Code states:

2 Except as otherwise provided in this chapter, any person who permits the
3 compounding or dispensing of prescriptions, or the furnishing of dangerous drugs in
4 his or her pharmacy, except by a pharmacist, is guilty of a misdemeanor.

4 18. Section 4333 of the Code states, in pertinent part, that all prescriptions filled by a
5 pharmacy and all other records required by Section 4081 shall be maintained on the premises and
6 available for inspection by authorized officers of the law for a period of at least three years. In
7 cases where the pharmacy discontinues business, these records shall be maintained in a
8 board-licensed facility for at least three years.

9 19. Section 4059 of the Code states:

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

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

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

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

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

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

23 **STATE REGULATORY AUTHORITY**

24 20. California Code of Regulations, title 16, section 1714, states:

25 (a) All pharmacies (except hospital inpatient pharmacies as defined by Business
26 and Professions Code section 4029 which solely or predominantly furnish drugs to
27 inpatients of the hospital) shall contain an area which is suitable for confidential
28 patient counseling.

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

5 (c) The pharmacy and fixtures and equipment shall be maintained in a clean and
6 orderly condition. The pharmacy shall be dry, well-ventilated, free from rodents and
7 insects, and properly lighted. The pharmacy shall be equipped with a sink with hot
8 and cold running water for pharmaceutical purposes.

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

14 (e) The pharmacy owner, the building owner or manager, or a family member of
15 a pharmacist owner (but not more than one of the aforementioned) may possess a key
16 to the pharmacy that is maintained in a tamper evident container for the purpose of 1)
17 delivering the key to a pharmacist or 2) providing access in case of emergency. An
18 emergency would include fire, flood or earthquake. The signature of the pharmacist-
19 in-charge shall be present in such a way that the pharmacist may readily determine
20 whether the key has been removed from the container.

21 (f) The board shall require an applicant for a licensed premise or for renewal of
22 that license to certify that it meets the requirements of this section at the time of
23 licensure or renewal.

24 (g) A pharmacy shall maintain a readily accessible restroom. The restroom shall
25 contain a toilet and washbasin supplied with running water.

26 COSTS

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

DRUGS

22 22. Oxycontin, a brand name formation of oxycodone hydrochloride and/or Oxycodone
23 SR, is an opioid agonist and a Schedule II controlled substance with an abuse liability similar to
24 morphine. OxyContin is for use in opioid tolerant patients only. It is a Schedule II controlled
25 substance pursuant to Health and Safety Code section 11055, subdivision (b)(1), and a dangerous
26 drug pursuant to Business and Professions Code section 4022.

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1 23. Dilaudid is a trade name for Hydromorphone, an Opium derivative, which is
2 classified as a Schedule II Controlled Substance pursuant to Health and Safety Code section
3 11055, subdivision (b)(1), and is a dangerous drug within the meaning of Business and
4 Professions Code section 4022.

5 24. Hydrocodone is in Schedule II of the Controlled Substances Act. Lortab, Norco and
6 Vicodin, brand/trade names of preparations containing hydrocodone in combination with other
7 non-narcotic medicinal ingredients, are in Schedule III pursuant to Health and safety Code section
8 11056(e)(4), and are categorized as dangerous drugs pursuant to section 4022.

9 **FACTS**

10 **Respondent L M Caldwell Pharmacist- Pueblo Street, Respondent L M Caldwell**
11 **Pharmacist- State Street, Respondent Caldwell, and Respondent Yahyavi.**

12 25. Respondent L M Caldwell Pharmacist- State Street and Respondent L M Caldwell
13 Pharmacist- Pueblo Street (collectively Respondents L M Caldwell Pharmacists) are pharmacies
14 operating in the Santa Barbara area.

15 26. Respondent Caldwell is the Pharmacists in Charge at Respondent L M Caldwell
16 Pharmacist- State Street and Respondent Yahyani is the Pharmacists in Charge at Respondent L
17 M Caldwell Pharmacist- Pueblo Street.

18 27. Pharmacy Technician DLM¹ was employed at Respondent Caldwell Pharmacists-
19 State Street.

20 **Acquisition, Disposition and Storage of Drugs**

21 28. Drugs acquired by Respondents L M Caldwell Pharmacists were stored at
22 Respondent L M Caldwell Pharmacists-State Street. Drugs were sent to Respondent L M
23 Caldwell Pharmacist-Pueblo Street as needed. Drug recordkeeping included a transfer document
24 which showed the bottles sent to Respondent L M Caldwell Pharmacist-Pueblo Street. However,
25 the documentation did not include whether the drugs were initially received at Respondent L M
26 Caldwell Pharmacist-Pueblo Street and then sent to Respondent L M Caldwell Pharmacist-State

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28 ¹ Initials are used to protect confidentiality. Identities will be revealed during discovery.

1 Street before being transferred back. Also the records for Respondent L M Caldwell Pharmacist-
2 Pueblo Street were located at Respondent L M Caldwell Pharmacist-State Street.

3 29. Between November 15, 2009 and July 13, 2011, Respondent L M Caldwell
4 Pharmacist- State Street and Respondent Caldwell could not account for an inventory overage
5 (disposition greater than acquisition) of 55,370 tablets of Hydrocodone/acetaminophen 10/325 mg
6 and 165 tablets of Oxycodone SR 80 mg. Between August 6, 2011 and January 15, 2013,
7 Respondent L M Caldwell Pharmacist- State Street could not account for an inventory overage of
8 78,746 tablets of Hydrocodone/Acetaminophen 10/325 mg.

9 30. Between December 18, 2010 and December 17, 2012, Respondent L M Caldwell
10 Pharmacist- Pueblo Street and Respondent Yahyani could not account for an inventory overage of
11 53,811 tablets of Hydrocodone/Acetaminophen 10/325 mg.

12 **Operational Standards and Security**

13 31. Respondent Caldwell was responsible for the security and record keeping at
14 Respondents L M Caldwell Pharmacists. Between November 15, 2009 to July 13, 2011,
15 Respondent L M Caldwell Pharmacist-State Street and Respondent Caldwell could not account
16 for 5,360 tablets of Hydromorphone 8 mg. Between August 6, 2011 to January 15, 2013,
17 Respondent L M Caldwell Pharmacist-State Street could not account for 8,800 tablets of
18 Hydromorphone 8 mg and 605 tablets of Oxycodone 30 mg.

19 32. Respondents L M Caldwell Pharmacists failed to maintain an effective control on the
20 security of the prescription department against theft or loss of controlled substance/ dangerous
21 drugs.

22 **Furnishing of Dangerous Drugs or Devices**

23 33. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell
24 Pharmacist-State Street and Respondent Caldwell sold Hydrocodone/Acetaminophen 10/325 mg
25 to Respondent L M Caldwell Pharmacists- Pueblo Street without adequate sales records.

26 34. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell
27 Pharmacist-Pueblo Street purchased Hydrocodone/Acetaminophen 10/325 mg from Respondent L
28 M Caldwell Pharmacist-State Street without adequate purchase records.

1 **Arrest and Conviction**

2 35. On April 29, 2011, the Board received an arrest report from the California
3 Department of Justice for Pharmacy Technician DLM who had been arrested on allegations that
4 he stole Oxycontin from his employer Respondent L M Caldwell Pharmacist and sold the drugs to
5 an undercover detective. In May of 2011, Pharmacy Technician DL M, following a plea, was
6 convicted of the sale of a controlled substance Oxycontin under Health and Safety Code section
7 11352, subdivision (a).

8 **Board Inspections and Audits**

9 36. On July 13, 2011 and January 1, 2013, the Board inspected Respondents Caldwell
10 Pharmacists. The Board also conducted audits of Respondents Caldwell Pharmacists for the
11 following time periods: November 15, 2009 to July 13, 2011 and August 6, 2011 to January 15,
12 2013.

13 37. On April 8, 2013, the Board issued a written Notice of Noncompliance to Respondent
14 L M Caldwell Pharmacists-State Street and Respondent Caldwell. The Board also issued a
15 written Notice of Noncompliance to Respondent L M Caldwell Pharmacists-Pueblo Street and
16 Respondent Yahyani.

17 **FIRST CAUSE FOR DISCIPLINE**

18 **(Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacy)**
19 **(Against Respondent L M Caldwell Pharmacist -State Street)**

20 38. Respondent L M Caldwell Pharmacist -State Street is subject to discipline under
21 section 4301, subsection (o) of the Code, and/or California Code of Regulations, title 16, section
22 1714, subsection (b), for failure to maintain its facilities, space, fixtures, and equipment so that
23 drugs are safely and properly prepared, maintained, secured and distributed. The circumstances
24 are as follows:

25 a. Between November 15, 2009 to July 13, 2011, Respondent L M Caldwell
26 Pharmacist-State Street could not account for 5,360 tablets of Hydromorphone 8 mg. Between
27 August 6, 2011 to January 15, 2013, Respondent L M Caldwell Pharmacist-State Street could not
28 account for 8,800 tablets of Hydromorphone 8 mg and 605 tablets of Oxycodone 30 mg.

1 **SECOND CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct: Lack of Operational Standards and Security- Pharmacist)**

3 **(Against Respondent Caldwell)**

4 39. Respondent Caldwell is subject to discipline under section 4301, subdivision (o), of
5 the Code, and California Code of Regulations, title 16, section 1714, subdivision (d), for failure to
6 maintain the security of the prescription department, including provisions for effective control
7 against theft or diversion of dangerous drugs and devices, and records for such drugs and devices
8 and to ensure that possession of a key to the pharmacy where dangerous drugs and controlled
9 substances are stored is restricted to pharmacists. The circumstances are as follows:

10 a. Between November 15, 2009 to July 13, 2011, Respondent Caldwell could not
11 account for 5,360 tablets of Hydromorphone 8 mg. Between August 6, 2011 to January 15, 2013,
12 Respondent Caldwell could not account for 8,800 tablets of Hydromorphone 8 mg and 605 tablets
13 of Oxycodone 30 mg.

14 **THIRD CAUSE FOR DISCIPLINE**

15 **(Failure to Maintain Records of Acquisition and Disposition of Dangerous Drugs)**

16 **(Against L M Caldwell Pharmacist- State Street, Respondent L M Caldwell Pharmacist-
17 Pueblo Street, Respondent Caldwell, and Respondent Yahyani)**

18 40. Respondent L M Caldwell Pharmacist- State Street, Respondent L M Caldwell
19 Pharmacist- Pueblo Street, Respondent Caldwell and Respondent Yahyani, are each and severally
20 subject to disciplinary action under section 4081, subdivision (a), and section 4105, of the Code,
21 for failure to maintain all records of acquisition or disposition of dangerous drugs at all times
22 open to inspection and preserved for at least three years from the date of making. The
23 circumstances are as follows:

24 a. Respondent L M Caldwell Pharmacist- State Street and Respondent Caldwell could
25 not account for the records of acquisition and disposition and the current inventory. Between
26 November 15, 2009 and July 13, 2011, Respondent L M Caldwell Pharmacist- State Street could
27 not account for an inventory overage (disposition greater than acquisition) of 55,370 tablets of
28 Hydrocodone/acetaminophen 10/325 mg and 165 tablets of Oxycodone SR 80 mg. Between

1 August 6, 2011 and January 15, 2013, Respondent L M Caldwell Pharmacist- State Street could
2 not account for an inventory overage of 78,746 tablets of Hydrocodone/acetaminophen 10/325
3 mg.

4 b. Between December 18, 2010 and December 17, 2012, Respondent L M Caldwell
5 Pharmacist- Pueblo Street and Respondent Yahyani could not account for an inventory overage of
6 53,811 tablets of Hydrocodone/Acetaminophen 10/325 mg.

7 **FOURTH CAUSE FOR DISCIPLINE**

8 **(Failure to Provide Drugs Sales and Purchase Records After Furnishing Dangerous Drugs)**
9 **(Against L M Caldwell Pharmacist- State Street, Respondent L M Caldwell Pharmacist-**
10 **Pueblo Street, Respondent Caldwell and Respondent Yahyani)**

11 41. Respondent L M Caldwell Pharmacist- State Street, Respondent L M Caldwell
12 Pharmacist- Pueblo Street, Respondent Caldwell and Respondent Yahyani, are each and severally
13 subject to disciplinary action under section 4081, subdivision (a), and section 4105, of the Code,
14 for failure to maintain all records of acquisition or disposition of dangerous drugs at all times
15 open to inspection and preserved for at least three years from the date of making. The
16 circumstances are as follows:

17 a. Between July 23, 2010 and December 28, 2012, Respondent L M Caldwell
18 Pharmacist-State Street and Respondent Caldwell sold Hydrocodone/Acetaminophen 10/325 mg
19 to Respondent Caldwell Pharmacists- Pueblo Street without adequate sales records.

20 b. Between July 23, 2010 and December 28, 2012, L M Caldwell Pharmacist-Pueblo
21 Street and Respondent Yahyani purchased Hydrocodone/Acetaminophen 10/325 mg from
22 Caldwell Pharmacist-State Street without adequate purchase records.

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1 **DISCIPLINE CONSIDERATIONS**

2 42. To determine the degree of discipline, if any, to be imposed on Respondent L M
3 Caldwell Pharmacists-Pueblo Street, Complainant alleges that on or about February 27, 2007, in a
4 prior action, the Board of Pharmacy issued Citation Number CI 2006-32134 against Respondent
5 L M Caldwell Pharmacist-Pueblo Street for violating California Code of Regulations, title 16,
6 section 1716. A copy of the citation is attached as Exhibit A. That Citation is now final and is
7 incorporated as if fully set forth. Complainant further alleges that on or about November 14,
8 2008, in a prior action, the Board of Pharmacy issued Citation Number CI 2007-35415 against
9 Respondent L M Caldwell Pharmacists-Pueblo Street for violating California Code of
10 Regulations, title 16, section 1716. A copy of the citation is attached as Exhibit B. That
11 Citation is now final and is incorporated as if fully set forth.

12 43. To determine the degree of discipline, if any, to be imposed on Respondent Yahyavi,
13 Complainant alleges that on or about February 27, 2007, in a prior action, the Board of Pharmacy
14 issued Citation Number CI 2006-32988 against Respondent Yahyavi and ordered him to pay fines
15 in the amount of \$ 250.00 for violating California Code of Regulations, title 16, section 1716. A
16 copy of the citation is attached as Exhibit C. That Citation is now final and is incorporated as if
17 fully set forth. Complainant further alleges that on or about November 14, 2008, in a prior action,
18 the Board of Pharmacy issued Citation Number CI 2008-37974 against Respondent Yahyavi and
19 ordered him to pay fines in the amount of \$750.00 for violating California Code of Regulations,
20 title 16, section 1716. A copy of the citation is attached as Exhibit D. That Citation is now
21 final and is incorporated as if fully set forth.

22 **PRAYER**

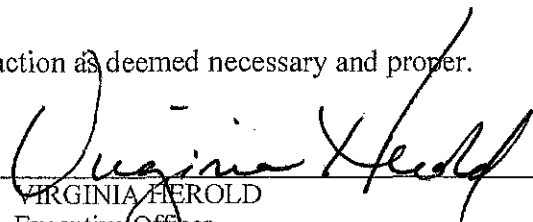
23 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
24 and that following the hearing, the Board of Pharmacy issue a decision:

- 25 1. Revoking or suspending Pharmacy Permit Number PHY 30911, issued to Peter
26 Caldwell to do business as L M Caldwell Pharmacist;
- 27 2. Revoking or suspending Pharmacy Permit Number PHY 30912, issued to Peter
28 Caldwell to do business as L M Caldwell Pharmacist;

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- 3. Revoking or suspending Pharmacist License Number 25356, issued to Peter Craig Caldwell;
- 4. Revoking or suspending Pharmacist License Number 30041, issued to Abdul Yahyavi;
- 6. Ordering L M Caldwell Pharmacist (PHY 30911), L M Caldwell Pharmacist (PHY 30912), Peter Craig Caldwell, and Abdul Yahyavi to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;
- 7. Taking such other and further action as deemed necessary and proper.

DATED: 1/8/14


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

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