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

In the Matter of the Accusation Against: **TAN DO, d.b.a. MOJAVE PHARMACY** Pharmacy Permit No. PHY 47150 **TAN DO** Pharmacist License No. RPH 47372 Respondents.	Case No. 5315 OAH No. 2016010419

DECISION AND ORDER

The attached Proposed Decision of the Administrative Law Judge 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 April 20, 2017.

It is so ORDERED on March 21, 2017.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By ______________________
Amy Gutierrez, Pharm.D.
Board President

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

In the Matter of the Accusation Against: TAN DO, d.b.a. MOJAVE PHARMACY, Pharmacy Permit No. PHY 47150 TAN DO Pharmacist License No. RPH 47372 Respondent.	Case No. 5315 OAH No. 2016010419

PROPOSED DECISION

Matthew Goldsby, Administrative Law Judge with the Office of Administrative Hearings, heard this matter on January 30, 2017, at Los Angeles, California.

Morgan W. McCall and William D. Gardner, Deputies Attorney General, appeared and represented complainant Virginia Herold, Executive Officer of the Board of Pharmacy, Department of Consumer Affairs, State of California (Board).

Herb L. Weinberg, Attorney at Law, appeared and represented respondent Tan Do, individually and doing business as Mojave Pharmacy, who was present.

The parties submitted the matter for decision at the conclusion of the hearing on January 30, 2017.

FACTUAL FINDINGS

1. Complainant brought the Accusation in her official capacity. Respondent timely submitted a Notice of Defense.

2. On October 17, 1994, the Board issued Pharmacist License number RPH 47372 to respondent. The Original Pharmacist License is valid and is scheduled to expire on February 28, 2018. On July 14, 2005, the Board issued Pharmacy Permit number PHY 47150 to respondent, doing business as Mojave Pharmacy. The Pharmacy Permit is valid

and is scheduled to expire on July 1, 2017. There is no record of prior disciplinary action against respondent's license or permit.

3. On August 19, 2013, the Board received an anonymous complaint, alleging respondent failed to follow "the guidelines and standards set by the Board." (Ex. 5, p. 0082.) The complaint described an incident pertaining to a patient for whom respondent refilled a prescription of Norco without approval of the prescribing doctor. The complaint also described recurring incidents for another patient whereby respondent received two prescriptions for 30 mg of oxycodone written by one doctor, and billed one prescription to Medi-Cal and charged the patient in cash for the other prescription. This patient allegedly became enraged when respondent did not have enough oxycodone to fill his prescription.

4. The Board assigned Sejal Desai, Board Inspector and a licensed pharmacist, to investigate the complaint. Inspector Desai was trained and familiar with "red flags" that could alert a pharmacist that a prescription ordered for a controlled drug may not be appropriate. "Those red flags include irregularities on the face of the prescription itself; . . . Cash payments; . . . Multiple patients at the same address; . . . Prescriptions for unusually large amounts or for duplicate of drugs; . . . Initial prescriptions written for stronger opiates; long distances traveled from patient home to the prescriber's office or pharmacy; prescriptions written outside the prescriber's medical specialty; [and] prescriptions for medication with no logical connection to diagnosis or treatment." (Ex. A, p.2.)

5. On October 30, 2013, inspector Desai appeared at the business location of Mojave Pharmacy and interviewed respondent, the pharmacist-in-charge. Inspector Desai reviewed the pharmacy's drug inventories, its drug usage reports, selected patient prescription profiles, drug acquisition records, and reports from the Controlled Substance Utilization Review and Evaluation System (CURES).[1]

6. CURES records showed that in a 21-month period from January 1, 2012, to September 5, 2013 (Inspection Period), respondent dispensed 15,694 prescriptions for controlled substances. Of those prescriptions for controlled substances, 26.74 percent or 4,197 prescriptions were written by one physician, Dr. Ashmead Ali. Inspector Desai reviewed online Medical Board records and determined that Dr. Ali is primarily a general practitioner with secondary practices in "family medicine" and "internal medicine," with no specialty in pain management. (Ex. 7, p. 0087.)

7. After reviewing data from CURES and respondent's patient history reports, inspector Desai determined that, of the 4,197 prescriptions written by Dr. Ali during the Inspection Period, 13.89 percent or 583 prescriptions were for 30 mg tablets of oxycodone, dispensed to the same 11 patients in quantities of 180 to 240 tablets per month. Respondent dispensed oxycodone to each of the 11 patients for more than one year, seven patients receiving monthly refills of the same prescription for the entire Inspection Period.

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[1] CURES is "California's prescription drug monitoring program for controlled substances and is operated under the California Department of Justice." (Ex. A, p. 14.)

8. For eight of the 11 patients, respondents repeatedly dispensed promethazine with codeine in high dosage. For example, for patient JM, respondent dispensed 473 ml (approximately 16 ounces) of promethazine-DM syrup on January 12, 2012, February 10, 2012, March 8, 2012, April 5, 2012, May 8, 2012, June 6, 2012, July 3, 2012, August 2, 2012, September 5, 2012, October 1, 2012, October 31, 2012, December 3, 2012, January 2, 2013, and January 31, 2013. On many of these same dates, respondent also regularly dispensed to patient JM 180 oxycodone 30 mg tablets, azithromycin (an anti-biotic), diazepam, alprazolam, and other prescription medications.

9. Inspector Desai credibly testified that promethazine with codeine is typically prescribed for temporary cough relief over the course of five days, after which a pharmacist is expected to refer the patient back to the doctor. Moreover, when taken with oxycodone at the doses and frequencies that respondent was dispensing the cough medication, promethazine with codeine is potentially dangerous, and "overdosing on prescription syrup is potentially fatal." (Ex. 22.) These prescriptions for unusually large amounts of promethazine with codeine should have alerted respondent that the prescriptions ordered for a controlled drug may not be appropriate. No evidence was presented to show that respondent took any action to verify that the ordered prescriptions were for legitimate medical purposes.

10. For three of the 11 patients over the same period, respondents repeatedly dispensed Vicodin, a combination of hydrocodone and acetaminophen. At the time, hydrocodone was a schedule III controlled substance under California Health and Safety Code section 11055, subdivision (b)(1)(I), and is a dangerous drug pursuant to Business and Professions Code section 4022. Vicodin is potentially dangerous when taken in combination with oxycodone because they are both narcotics. No evidence was presented to show that the prescriptions for two narcotics with a potentially dangerous combined effect had any logical connection to a diagnosis or treatment. These prescriptions for unusually large amounts or for duplicate drugs should have alerted respondent that the prescriptions might not have been appropriate. No evidence was presented to show that respondent took any action to verify that the ordered prescriptions were for legitimate medical purposes.

11. Six of the 11 patients paid in a combination of cash and insurance. For patient EP, Dr. Ali wrote two prescriptions for 30 mg of oxycodone – one for 150 pills, the other for 90 pills - on June 7, 2012, and February 23, 2012. He did the same for patient ST on May 21, 2012. Respondent dispensed these amounts, with no record of an inquiry into the legitimacy of these prescriptions, and charged the patient's insurance company or Medi-Cal for one of the two prescriptions, but not the other. For cash patients, Dr. Ali wrote one prescription per month for 240 oxycodone pills (30 mg) and respondent dispensed that amount, generally charging $270-$280 per month. Cash payments for a controlled substance should have alerted respondent that the prescriptions might not have been appropriate. No evidence was presented to show that respondent took any action to verify that the ordered prescriptions were for legitimate medical purposes.

12. During Inspector Desai's investigation, respondent acknowledged that he retained no records or notes relating to the patients, their diagnoses, or their treatments. Respondent stated to Inspector Desai that he had questioned Dr. Ali regarding excessive prescribing of pain medications and falsely represented to the inspector that Dr. Ali was a specialist in pain management. He admitted that he did not access CURES to check on patient's medication histories.[2] He represented to the inspector that he had reviewed records obtained from the prescribing physicians, but had no records to corroborate those statements. Respondent did not have a practice of verifying whether a patient's prescriptions were appropriate for the patient's diagnosis until questioned by inspector Desai.

13. Inspector Desai examined the distances traveled by patients. Dr. Ali has offices in two locations, one in California City and the other located two doors away from Mojave Pharmacy. Most patients lived in California City, where they were examined by Dr. Ali and where other licensed pharmacies operated. In spite of their close proximity to other pharmacies, patients drove 30 miles round-trip in order to have Mojave Pharmacy fill their prescriptions. Some patients traveled over 260 miles round-trip to pick up prescriptions of oxycodone at Mojave Pharmacy. Long distances traveled by patients should have alerted respondent that the prescriptions for controlled substances may not have been appropriate. No evidence was presented to show that respondent took any action to verify that the ordered prescriptions were for legitimate medical purposes

14. Inspector Desai determined that respondent dispensed oxycodone to four pairs of patients who lived at the same residence. Specifically, patient EP lived at the same address as patient ST, patient LH lived at the same address as patient TH, patient EG lived at the same address as patient OG, and patient JS lived at the same address as patient SM. Multiple patients at the same address should have alerted respondent that the prescriptions may not have been appropriate. No evidence was presented to show that respondent took any action to verify that the ordered prescriptions were for legitimate medical purposes.

15. Ten days before the hearing, respondent implemented a corrective action plan "in order to avoid violations of Health and Safety Code section 11153, and to be certain that the pharmacy and pharmacists comply with their respective Corresponding Responsibilities." (Ex. B.) In general, the corrective action plan prohibits dispensing controlled substances without checking the CURES program for indications of "doctor or pharmacy shopping" and to consider other "red flags" similar to those set forth in Factual Finding 4. (Ex. B.)

16. Respondent presented character reference letters from four patients. These letters describe respondent as "a man of great integrity," "honest to a fault," and having "expert knowledge of medication and their administration." (Ex. C.) Only one of the letters referenced the issues raised by the Accusation, stating "Personally I don't think [respondent] should not [*sic*] be punished for anything that Dr. Ashmead Ali has done. . . . Mojave needs a

[2] Effective January 1, 2016, all California licensed pharmacists must be registered to access CURES. However, during the Inspection Period, registration in CURES was voluntary. (Ex. A, p. 14.)

pharmacy. The town was without a pharmacist for close to 25 years. Don't punish him or the people of Mojave for somebody else's bad judgment." (Ex. C, p. 4.) Respondent did not call any witness to testify. No evidence was presented to show that respondent has any criminal record.

17. Respondent has been married for 30 years and has three children, ages 26, 21, and 19. All three of his children are enrolled in college and respondent pays for their education. His oldest child, a daughter, was diagnosed six weeks before the hearing with Ewing's sarcoma, a rare form of cancer, and is currently receiving treatment.

18. Complainant incurred prosecution costs in the amount of $10,397.50 and investigation costs in the amount of $4,028.50. These costs totaling $14,426 were supported by a declaration and are reasonable considering the complexity of the case.

LEGAL CONCLUSIONS

1. As the party bringing administrative charges and seeking discipline against the respective licensees in this case, complainant bears the burden of proof. (*Parker v. City of Fountain Valley* (1981) 127 Cal.App.3d 99, 113; *Brown v. City of Los Angeles* (2002) 102 Cal.App.4th 155.)

2. In an action seeking disciplinary action against a professional license, the governing agency bears the burden of establishing cause for discipline by clear and convincing proof to a reasonable certainty. (*Ettinger v. Board of Med. Quality Assurance* (1982) 135 Cal.App.3d 853, 857.)

3. The Board is mandated to take disciplinary action against any licensee who is guilty of unprofessional conduct. (Bus. & Prof. Code, § 4301.)

4. Unprofessional conduct for a pharmacist may include acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances or dangerous drugs. (Bus. & Prof. Code, § 4306.5, subd. (b).)

5. Unprofessional conduct includes clearly excessive furnishing of controlled substances in violation of Health and Safety Code section 11153, subdivision (a). (Bus. & Prof. Code, § 4301, subd. (d).) Health and Safety Code section 11153, subdivision (a), provides:

> 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.

6. Factors to be considered in determining whether the furnishing of controlled substances is clearly excessive include, but are not limited to, the amount of controlled substances furnished, the previous ordering pattern of the customer (including size and frequency of orders), the type and size of the customer, and where and to whom the customer distributes its product. (Bus. & Prof. Code, § 4301, subd. (e).)

7. In this case, respondent failed to exercise or implement his best professional judgment with regard to the dispensing of controlled substances. Respondent took no action to verify the legitimacy of prescriptions ordered by Dr. Ali, in spite of numerous red flags that should have alerted him that the ordered prescriptions may not have been appropriate. Respondent ignored key factors showing the medical illegitimacy of the ordered prescriptions and he failed to appropriately scrutinize the patients' drug therapy by referring to data available through CURES or his own patient history reports.

8. Respondent's reliance entirely on the prescriptions ordered by Dr. Ali was a breach of respondent's corresponding responsibility to assure that numerous prescriptions for controlled substances were issued for a legitimate medical purpose. He failed to consider that Dr. Ali was not a specialist in pain management and neglected to document any inquiries he may have had with Dr. Ali in relation to any efforts made to verify the legitimacy of the prescriptions.

9. Respondent regularly and redundantly dispensed large amounts of high doses of oxycodone and other controlled substances. Taking into account the prescribing patterns of Dr. Ali, including the size and monthly regularity of his patients' prescriptions, the patients' payment methods and the distances they traveled, respondent knowingly furnished excessive amounts of controlled substances in violation of Health and Safety Code section 11153, subdivision (a). This constitutes unprofessional conduct within the meaning of Business and Professions Code section 4301, subdivision (d), and 4306.5, subdivision (b).

10. Cause exists to discipline respondent's permit and license because clear and convincing evidence has shown that his furnishing of controlled substances was clearly excessive and that he engaged in unprofessional conduct.

11. In determining the appropriate penalty is to be imposed for respondent's violations of the Pharmacy Law[3] in this case, the Board's Disciplinary Guidelines are to be considered. (Cal. Code Regs, tit. 16, § 1760.) In this case, respondent has no record of prior discipline and no known criminal record, and he presented character reference letters to support his testimony that he intends to comply with his recently implemented corrective action plan. However, the nature and severity of his misconduct outweighs the moderate evidence of rehabilitation. The potential harm to the patients was substantial and potentially fatal, considering the amount of oxycodone, Vicodin, promethazine with codeine, and other medications that respondent was dispensing. The potential harm extends to the general public because drug abuse may adversely impact families and communities, and cause public health and social problems.

12. Imposing discipline on respondent's license and permit furthers a particular social purpose: the protection of the public. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757.) Protection of the public is the highest priority for the Board in exercising its disciplinary functions, and whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. (Bus. & Prof. Code, § 4001.1.) Having considered the Board's Disciplinary Guidelines and the weight of all evidence, license revocation is necessary to protect the public.

13. A finding of a licensee's multiple violations of the Pharmacy Law entitles the Board to recover all reasonable costs incurred to investigate and prosecute the violation. (Bus. & Prof. Code, § 125.3.)

14. Complainant has presented satisfactory proof that reasonable costs were incurred in the amount of $14,426 to investigate and enforce the case against respondent by reason of Finding 18. However, In *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the Supreme Court enumerated several factors that a licensing agency must consider in assessing costs. It must not assess the full costs of investigation and enforcement when to do so would unfairly penalize a respondent who has committed some misconduct, but who has used the hearing process to obtain the dismissal of some charges or a reduction in the severity of the penalty. The agency must also consider a respondent's subjective good faith belief in the merits of his or her position and whether the respondent has raised a colorable challenge to the discipline or is unable to pay.

15. Ordering respondent to pay costs in addition to revoking his licenses would be unduly punitive under the circumstances. Accordingly, complainant's costs are allowed in the amount of $14,426, but payment is deferred until such time as respondent successfully petitions the Board for reinstatement of his license or permit, or applies for the issuance of a new license.

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[3] Bus. & Prof. Code, § 4000 et seq.

ORDER

1. Pharmacist License number RPH 47372 issued to respondent Tan Do is revoked.

2. Pharmacy Permit number PHY 47150 issued to respondent Tan Do doing business as Mojave Pharmacy is revoked.

3. Respondent shall pay the Board $14,426 as a condition precedent to the Board's reinstatement of respondent's license and/or permit, or to the issuance of a new license.

DATED: February 28, 2017

DocuSigned by:
Matthew Goldsby
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MATTHEW GOLDSBY
Administrative Law Judge
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BEFORE THE
BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

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

Complainant alleges:

PARTIES

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

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

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

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JURISDICTION

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

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

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

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

(1) Suspending judgment.

(2) Placing him or her upon probation.

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

(4) Revoking his or her license.

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

. . .

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

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

STATUTES

7. Section 4301 authorizes discipline for unprofessional conduct:

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

. . .

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

. . .

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

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

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

5 . . .

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

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

12 (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
13 of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a
14 corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1)
15 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
16 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
17 the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use."

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COST RECOVERY

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

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FIRST CAUSE FOR DISCIPLINE

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(AS TO MOJAVE PHARMACY AND TAN DO)

24

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

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

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

The circumstances are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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SECOND CAUSE FOR DISCIPLINE

(AS TO MOJAVE PHARMACY AND TAN DO)

(Excessive Furnishing of Controlled Substances)

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

PRAYER

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

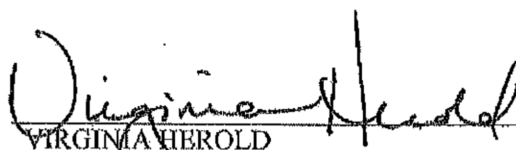
1. Revoking or suspending Original Pharmacy Permit Number PHY 47150, issued to Mojave Pharmacy;

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

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

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

DATED: 7/2/15



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

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