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

In the Matter of the Accusation Against:

WALZAIN, INC., DBA THE MEDICINE SHOPPE; ROUSEL NABIL AL ROUBAE CEO/DIR./SEC./TREAS./CFO, PHY 55851

and

ROUSL NABIL AL ROUBAE, RPH 72775

Respondents

Case number 6777

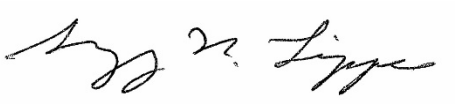
DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on February 4, 2021.

It is so ORDERED on January 5, 2021.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA



By

Greg Lippe
Board President

XAVIER BECERRA
Attorney General of California
GREGORY J. SALUTE
Supervising Deputy Attorney General
STEPHEN A. ARONIS
Deputy Attorney General
State Bar No. 204995
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9451
Facsimile: (619) 645-2581
Attorneys for Complainant

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

In the Matter of the Accusation Against: **WALZAIN, INC., DBA THE MEDICINE SHOPPE; ROUSL NABIL AL ROUBAE CEO/DIR./SEC./TREAS./CFO** **2939 Alta View Drive, Ste. L** **San Diego, CA 92139** **Pharmacy Permit No. PHY 55851,** **and** **ROUSL NABIL AL ROUBAE** **P.O. Box 1997** **Bonita, CA 91908** **Pharmacist License No. RPH 72775** Respondents.	Case No. 6777 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

///

///

PARTIES

1. Anne Sodergren (Complainant) is the Executive Officer of the Board of Pharmacy (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Stephen A. Aronis, Deputy Attorney General.

2. Respondent Walzain, Inc., dba The Medicine Shoppe (Respondent The Medicine Shoppe) and Rousl Nabil Al Roubae (Respondent Rousl Al Roubae) are represented in this proceeding by Tony J. Park and Luis Andre P. Vizcocho of California Pharmacy Lawyers, whose address is: 55 Cetus, 1st Floor, Irvine, CA 92618.

3. On or about November 15, 2017, the Board of Pharmacy (Board) issued Pharmacy Permit No. PHY 55851 to Respondent The Medicine Shoppe. The Pharmacy Permit was in full force and effect at all times relevant to the charges brought in Accusation No. 6777, and will expire on November 1, 2021, unless renewed.

4. On or about July 9, 2015, the Board issued Pharmacist License Number RPH 72775 Respondent Rousl Al Roubae. The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2021, unless renewed.

JURISDICTION

5. Accusation No. 6777 was filed before the Board, and is currently pending against Respondents. The Accusation and all other statutorily required documents were properly served on Respondents on June 4, 2020. Respondents timely filed their Notice of Defense contesting the Accusation.

6. A copy of Accusation No. 6777 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

7. Respondents have carefully read, fully discussed with counsel, and understand the charges and allegations in Accusation No. 6777. Respondents have also carefully read, fully discussed with counsel, and understand the effects of this Stipulated Settlement and Disciplinary Order.

8. Respondents are fully aware of their legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against them; the right to present evidence and to testify on their 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. Respondents voluntarily, knowingly, and intelligently waive and give up each and every right set forth above.

CULPABILITY

10. Respondents admit the truth of each and every charge and allegation in Accusation Number 6777.

11. Respondents agree that their respective Pharmacy Permit and Pharmacist License are subject to discipline and agree to be bound by the Board's Disciplinary Order and probationary terms set forth below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Board of Pharmacy. Respondents understand and agree that counsel for Complainant and the staff of the Board of Pharmacy may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondents or their counsel. By signing the stipulation, Respondents understand and agree that they may not withdraw their agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Pharmacy Permit No. PHY 55851, issued to Respondent Walzain, Inc., doing business as The Medicine Shoppe (Respondent Medicine Shoppe), is surrendered and accepted by the Board. The effective date of the Decision as to Respondent The Medicine Shoppe's permit surrender, however, shall be stayed for 120 days from the effective date of the Decision, at which time the Board's acceptance of the surrender becomes effective and the Respondent The Medicine Shoppe must either be sold or closed.

1. The surrender of Respondent The Medicine Shoppe's Pharmacy Permit and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent The Medicine Shoppe. This stipulation constitutes a record of the discipline and shall become a part of Respondent The Medicine Shoppe's license history with the Board of Pharmacy.

2. Respondent The Medicine Shoppe shall lose all rights and privileges as a pharmacy in California as of the effective date of the Board's Decision and Order.

3. Respondent The Medicine Shoppe shall cause to be delivered to the Board its pocket license and, if one was issued, its wall certificate on or before 120 days after the effective date of the Decision and Order.

4. If Respondent The Medicine Shoppe ever applies for licensure or petitions for reinstatement in the State of California, the Board shall treat it as a new application for licensure.

Respondent The Medicine Shoppe must comply with all the laws, regulations and procedures for licensure in effect at the time the application or petition is filed, and all of the charges and allegations contained in Accusation No. 6708 shall be deemed to be true, correct and admitted by Respondent The Medicine Shoppe when the Board determines whether to grant or deny the application or petition.

5. If Respondent The Medicine Shoppe should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation No. 6777 shall be deemed to be true, correct, and admitted by Respondent The Medicine Shoppe for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

6. Respondent The Medicine Shoppe and Respondent Rousl Nabil Al Roubae shall be jointly and severally responsible for paying the Board its costs of investigation and prosecution in the amount of $16,000.00 and shall be liable to pay these costs, as set forth in term 17 below.

7. In the event that Respondent The Medicine Shoppe is not sold within 120 days of the date on which this Stipulated Surrender of License and Order is signed by Respondent The Medicine Shoppe, Respondent The Medicine Shoppe shall, within 10 days of the stayed effective date of the Board's order, arrange for the destruction of, the transfer to, sale of or storage in a facility licensed by the Board of all controlled substances and dangerous drugs and devices. Respondent The Medicine Shoppe shall further provide written proof of such disposition and submit a completed Discontinuance of Business form according to Board guidelines.

Respondent The Medicine Shoppe's owner shall also, by the effective date of this decision, arrange for the continuation of care for ongoing patients of the pharmacy by, at minimum, providing a written notice to ongoing patients that specifies the anticipated closing date of the pharmacy and that identifies one or more area pharmacies capable of taking up the patients' care, and by cooperating as may be necessary in the transfer of records or prescriptions for ongoing patients. Within five days of its provision to the pharmacy's ongoing patients, Respondent The Medicine Shoppe's owner shall provide a copy of the written notice to the Board. For the

purposes of this provision, "ongoing patients" means those patients for whom Respondent The Medicine Shoppe has on file a prescription with one or more refills outstanding, or for whom Respondent The Medicine Shoppe has filled a prescription within the preceding sixty (60) days.

7. During the 120 stay of the surrender of Respondent The Medicine Shoppe's permit, it shall hire an interim pharmacist-in-charge and Respondents agree that Respondent Rousl Nabil Al Roubae shall not be the pharmacist-in-charge during this stay.

8. Respondent The Medicine Shoppe may not apply, reapply, or petition for any Board-issued licensure or registration for three years from the effective date of the Decision and Order.

IT IS HEREBY FURTHER ORDERED that Pharmacist License No. RPH 72775 issued to Respondent Rousl Nabil Al Roubae is revoked. However, the revocation is stayed and Rousl Al Roubae is placed on probation for three years on the following terms and conditions:

9. **Obey All Laws**

Respondent Al Roubae shall obey all state and federal laws and regulations.

Respondent Al Roubae shall report any of the following occurrences to the board, in writing, within 72 hours of such occurrence:

- an arrest or issuance of a criminal complaint for violation of any provision of the Pharmacy Law, state and federal food and drug laws, or state and federal controlled substances laws
- a plea of guilty, or nolo contendere, no contest, or similar, in any state or federal criminal proceeding to any criminal complaint, information or indictment
- a conviction of any crime
- the filing of a disciplinary pleading, issuance of a citation, or initiation of another administrative action filed by any state or federal agency which involves Respondent Al Roubae's license or which is related to the practice of pharmacy or the manufacturing, obtaining, handling, distributing, billing, or charging for any drug, device or controlled substance.

Failure to timely report such occurrence shall be considered a violation of probation.

///

10. **Report to the Board**

Respondent Al Roubae shall report to the board quarterly, on a schedule as directed by the board or its designee. The report shall be made either in person or in writing, as directed. Among other requirements, Respondent Al Roubae shall state in each report under penalty of perjury whether there has been compliance with all the terms and conditions of probation.

Failure to submit timely reports in a form as directed shall be considered a violation of probation. Any period(s) of delinquency in submission of reports as directed may be added to the total period of probation. Moreover, if the final probation report is not made as directed, probation shall be automatically extended until such time as the final report is made and accepted by the Board.

11. **Interview with the Board**

Upon receipt of reasonable prior notice, Respondent Al Roubae shall appear in person for interviews with the Board or its designee, at such intervals and locations as are determined by the Board or its designee. Failure to appear for any scheduled interview without prior notification to Board staff, or failure to appear for two or more scheduled interviews with the Board or its designee during the period of probation, shall be considered a violation of probation.

12. **Cooperate with Board Staff**

Respondent Al Roubae shall timely cooperate with the Board's inspection program and with the Board's monitoring and investigation of Respondent Al Roubae's compliance with the terms and conditions of her probation, including but not limited to: timely responses to requests for information by Board staff; timely compliance with directives from Board staff regarding requirements of any term or condition of probation; and timely completion of documentation pertaining to a term or condition of probation. Failure to timely cooperate shall be considered a violation of probation.

13. **Continuing Education**

Respondent Al Roubae shall provide evidence of efforts to maintain skill and knowledge as a pharmacist as directed by the Board or its designee.

///

14. **Reporting of Employment and Notice to Employers**

During the period of probation, Respondent Al Roubae shall notify all present and prospective employers of the decision in case number 6777 and the terms, conditions and restrictions imposed on Respondent Al Roubae by the decision, as follows:

Within 30 days of the effective date of this decision, and within 10 days of undertaking any new employment, Respondent Al Roubae shall report to the Board in writing the name, physical address, and mailing address of each of her employer(s), and the name(s) and telephone number(s) of all of her direct supervisor(s), as well as any pharmacist(s)-in-charge, designated representative(s)-in-charge, responsible manager, or other compliance supervisor(s) and the work schedule, if known. Respondent Al Roubae shall also include the reason(s) for leaving the prior employment. Respondent Al Roubae shall sign and return to the Board a written consent authorizing the Board or its designee to communicate with all of Respondent Al Roubae's employer(s) and supervisor(s), and authorizing those employer(s) or supervisor(s) to communicate with the Board or its designee, concerning Respondent Al Roubae's work status, performance, and monitoring. Failure to comply with the requirements or deadlines of this condition shall be considered a violation of probation.

Within 30 days of the effective date of this decision, and within 15 days of Respondent Al Roubae undertaking any new employment, Respondent Al Roubae shall cause (a) her direct supervisor, (b) her pharmacist-in-charge, designated representative-in-charge, responsible manager, or other compliance supervisor, and (c) the owner or owner representative of her employer, to report to the Board in writing acknowledging that the listed individual(s) has/have read the decision in case number 6777, and terms and conditions imposed thereby. If one person serves in more than one role described in (a), (b), or (c), the acknowledgment shall so state. It shall be Respondent Al Roubae's responsibility to ensure that these acknowledgment(s) are timely submitted to the Board. In the event of a change in the person(s) serving the role(s) described in (a), (b), or (c) during the term of probation, Respondent Al Roubae shall cause the person(s) taking over the role(s) to report to the Board in writing within 15 days of the change

acknowledging that he or she has read the decision in case number 6777, and the terms and conditions imposed thereby.

If Respondent Al Roubae works for or is employed by or through an employment service, Respondent Al Roubae must notify the person(s) described in (a), (b), and (c) above at every entity licensed by the Board of the decision in case number 6777, and the terms and conditions imposed thereby in advance of Respondent Al Roubae commencing work at such licensed entity. A record of this notification must be provided to the Board upon request.

Furthermore, within 30 days of the effective date of this decision, and within fifteen (15) days of Respondent Al Roubae undertaking any new employment by or through an employment service, Respondent Al Roubae shall cause the person(s) described in (a), (b), and (c) above at the employment service to report to the Board in writing acknowledging that he or she has read the decision in case number 6777, and the terms and conditions imposed thereby. It shall be Respondent Al Roubae's responsibility to ensure that these acknowledgment(s) are timely submitted to the Board.

Failure to timely notify present or prospective employer(s) or failure to cause the identified person(s) with that/those employer(s) to submit timely written acknowledgments to the Board shall be considered a violation of probation.

"Employment" within the meaning of this provision includes any full-time, part-time, temporary, relief, or employment/management service position as a a pharmacist, or any position for which being a pharmacist is a requirement or criterion for employment, whether Respondent Al Roubae is an employee, independent contractor or volunteer.

15. **Notification of Change(s) in Name, Address(es), or Phone Number(s)**

Respondent Al Roubae shall further notify the Board in writing within 10 days of any change in name, residence address, mailing address, e-mail address or phone number.

Failure to timely notify the Board of any change in employer, name, address, or phone number shall be considered a violation of probation.

///

///

16. **Restrictions on Supervision and Oversight of Licensed Facilities**

During the period of probation, Respondent Al Roubae shall not supervise any intern pharmacist, be the pharmacist-in-charge, designated representative-in-charge, responsible manager or other compliance supervisor of any entity licensed by the Board, nor serve as a consultant. Assumption of any such unauthorized supervision responsibilities shall be considered a violation of probation.

17. **Reimbursement of Board Costs**

As a condition precedent to successful completion of probation, Respondent Al Roubae shall pay to the Board its costs of investigation and prosecution in the amount of $16,000.00. Respondent Al Roubae and Respondent The Medicine Shoppe shall be jointly and severally liable for these costs.

Respondent Al Roubae shall make said payments as follows:

Respondent Al Roubae shall be permitted to pay these costs in a payment plan approved by the Board or its designee, so long as full payment is completed no later than 1 year prior to the end date of probation.

There shall be no deviation from this schedule absent prior written approval by the Board or its designee. Failure to pay costs by the deadline(s) as directed shall be considered a violation of probation.

18. **Probation Monitoring Costs**

Respondent Al Roubae shall pay any costs associated with probation monitoring as determined by the Board each and every year of probation. Such costs shall be payable to the Board on a schedule as directed by the Board or its designee. Failure to pay such costs by the deadline(s) as directed shall be considered a violation of probation.

19. **Status of License**

Respondent Al Roubae shall, at all times while on probation, maintain an active, current Pharmacist License with the Board, including any period during which suspension or probation is tolled. Failure to maintain an active, current Pharmacist License shall be considered a violation of probation.

If Respondent Al Roubae's Pharmacist License expires or is cancelled by operation of law or otherwise at any time during the period of probation, including any extensions thereof due to tolling or otherwise, upon renewal or reapplication Respondent Al Roubae's license shall be subject to all terms and conditions of this probation not previously satisfied.

20. **License Surrender While on Probation/Suspension**

Following the effective date of this Decision, should Respondent Al Roubae cease practice due to retirement or health, or be otherwise unable to satisfy the terms and conditions of probation, Respondent Al Roubae may relinquish her pharmacist license, including any indicia of licensure issued by the Board, along with a request to surrender the license. The Board or its designee shall have the discretion whether to accept the surrender or take any other action it deems appropriate and reasonable. Upon formal acceptance of the surrender of the license, Respondent Al Roubae will no longer be subject to the terms and conditions of probation. This surrender constitutes a record of discipline and shall become a part of Respondent Al Roubae's license history with the Board.

Upon acceptance of the surrender, Respondent Al Roubae shall relinquish her pocket and/or wall license, including any indicia of licensure not previously provided to the Board within 10 days of notification by the Board that the surrender is accepted if not already provided. Respondent Al Roubae may not reapply for any license from the Board for 3 years from the effective date of the surrender. Respondent Al Roubae shall meet all requirements applicable to the license sought as of the date the application for that license is submitted to the Board, including any outstanding costs.

21. **Practice Requirement – Extension of Probation**

Except during periods of suspension, Respondent Al Roubae shall, at all times while on probation, be employed as a pharmacist in California for a minimum of 40 hours per calendar month for the first year of probation and for a minimum of 64 hours per calendar month for the remaining years of probation. Any month during which this minimum is not met shall extend the period of probation by one month. During any such period of insufficient employment,

Respondent Al Roubae must nonetheless comply with all terms and conditions of probation, unless Respondent Al Roubae receives a waiver in writing from the Board or its designee.

If Respondent Al Roubae does not practice as a pharmacist in California for the minimum number of hours in any calendar month, for any reason (including vacation), Respondent Al Roubae shall notify the Board in writing within 10 days of the conclusion of that calendar month. This notification shall include at least: the date(s), location(s), and hours of last practice; the reason(s) for the interruption or reduction in practice; and the anticipated date(s) on which Respondent Al Roubae will resume practice at the required level. Respondent Al Roubae shall further notify the Board in writing within 10 days following the next calendar month during which Respondent Al Roubae practices as a pharmacist in California for the minimum of hours. Any failure to timely provide such notification(s) shall be considered a violation of probation.

It is a violation of probation for Respondent Al Roubae's probation to be extended pursuant to the provisions of this condition for a total period, counting consecutive and non-consecutive months, exceeding 36 months. The Board or its designee may post a notice of the extended probation period on its website.

22. **Violation of Probation**

If Respondent Al Roubae has not complied with any term or condition of probation, the Board shall have continuing jurisdiction over Respondent Al Roubae, and the Board shall provide notice to Respondent Al Roubae that probation shall automatically be extended, until all terms and conditions have been satisfied or the Board has taken other action as deemed appropriate to treat the failure to comply as a violation of probation, to terminate probation, and to impose the penalty that was stayed. The Board or its designee may post a notice of the extended probation period on its website.

If Respondent Al Roubae violates probation in any respect, the Board, after giving Respondent Al Roubae notice and an opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If a petition to revoke probation or an accusation is filed against Respondent Al Roubae during probation, or the preparation of an accusation or petition to revoke probation is requested from the Office of the Attorney General, the Board shall have

continuing jurisdiction and the period of probation shall be automatically extended until the petition to revoke probation or accusation is heard and decided.

23. **Completion of Probation**

Upon written notice by the Board or its designee indicating successful completion of probation, Respondent Al Roubae's license will be fully restored.

24. **Remedial Education**

Within 60 days of the effective date of this Decision, Respondent Al Roubae shall submit to the Board or its designee, for prior approval, an appropriate program of remedial education 50 percent related to the grounds for discipline and 50 percent related to compounding. The program of remedial education shall consist of at least 10 hours per year of probation, 50 percent of which must be a live webinar or in person and completed at Respondent Al Roubae's own expense. All remedial education shall be in addition to, and shall not be credited toward, continuing education (CE) courses used for license renewal purposes for pharmacists.

Within the first year of probation, Respondent Al Roubae shall enroll in the Board's one-day diversion training program, "Prescription Drug Abuse and Diversion What a Pharmacist Needs to Know," at Respondent Al Roubae's expense. Respondent Al Roubae shall provide proof of enrollment upon request. Within 30 days of completion, Respondent Al Roubae shall submit a copy of the certificate of completion to the Board or its designee. Failure to timely enroll in the program, to initiate the program during the first year of probation, to successfully complete it before the end of the second year of probation, or to timely submit proof of completion to the Board or its designee, shall be considered a violation of probation.

Failure to timely submit for approval or complete the approved remedial education shall be considered a violation of probation. The period of probation will be automatically extended until such remedial education is successfully completed and written proof, in a form acceptable to the Board, is provided to the Board or its designee.

Following the completion of each course, the Board or its designee may require the Respondent Al Roubae, at her own expense, to take an approved examination to test the Respondent Al Roubae's knowledge of the course. If Respondent Al Roubae does not achieve a

passing score on the examination that course shall not count towards satisfaction of this term. Respondent Al Roubae shall take another course approved by the Board in the same subject area.

25. **Ethics Course**

Within 60 calendar days of the effective date of this Decision, Respondent Al Roubae shall enroll in a course in ethics, at Respondent Al Roubae's expense, approved in advance by the Board or its designee that complies with Title 16 California Code of Regulations section 1773.5. Respondent Al Roubae shall provide proof of enrollment upon request. Within 5 days of completion, Respondent Al Roubae shall submit a copy of the certificate of completion to the Board or its designee. Failure to timely enroll in an approved ethics course, to initiate the course during the first year of probation, to successfully complete it before the end of the second year of probation, or to timely submit proof of completion to the Board or its designee, shall be considered a violation of probation.

26. **No Ownership or Management of Licensed Premises**

Respondent Al Roubae shall not own, have any legal or beneficial interest in, nor serve as a manager, administrator, member, officer, director, trustee, associate, or partner of any business, firm, partnership, or corporation currently or hereinafter licensed by the Board. Respondent Al Roubae shall sell or transfer any legal or beneficial interest in any entity licensed by the Board within 120 days following the effective date of this Decision as required by this Stipulation and shall immediately provide written proof thereof to the Board, or if there is no sale or transfer, the licensed entity shall close 120 days after the effective date of this Decision, when its license surrender becomes effective.

///

///

///

///

///

///

///

ACCEPTANCE

We have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Tony J. Park and Luis Andre P. Vizcocho. We understand the stipulation and the effect it will have on our Pharmacy Permit and Pharmacist License. We enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: _____

ROUSL NABIL AL ROUBAE individually, and as the Chief Executive Officer and authorized agent on behalf of WALZAIN, INC., DBA THE MEDICINE SHOPPE
Respondents

I have read and fully discussed with Respondents Walzain, Inc., dba The Medicine Shoppe and Rousl Nabil Al Roubae the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____

LUIS ANDRE P. VIZCOCHO
Attorney for Respondents

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
GREGORY J. SALUTE
Supervising Deputy Attorney General

STEPHEN A. ARONIS
Deputy Attorney General
Attorneys for Complainant

SD2019701887
82597067.docx

ACCEPTANCE

We have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Tony J. Park and Luis Andre P. Vizcocho. We understand the stipulation and the effect it will have on our Pharmacy Permit and Pharmacist License. We enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 11-13-2020

ROUSL NABIL AL ROUBAE individually, and as the Chief Executive Officer and authorized agent on behalf of WALZAIN, INC., DBA THE MEDICINE SHOPPE
Respondents

I have read and fully discussed with Respondents Walzain, Inc., dba The Medicine Shoppe and Rousl Nabil Al Roubae the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____

LUIS ANDRE P. VIZCOCHO
Attorney for Respondents

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
GREGORY J. SALUTE
Supervising Deputy Attorney General

STEPHEN A. ARONIS
Deputy Attorney General
Attorneys for Complainant

SD2019701887
82597067.docx

ACCEPTANCE

We have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Tony J. Park and Luis Andre P. Vizcocho. We understand the stipulation and the effect it will have on our Pharmacy Permit and Pharmacist License. We enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: _____

ROUSL NABIL AL ROUBAE individually, and as the Chief Executive Officer and authorized agent on behalf of WALZAIN, INC., DBA THE MEDICINE SHOPPE
Respondents

I have read and fully discussed with Respondents Walzain, Inc., dba The Medicine Shoppe and Rousl Nabil Al Roubae the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 11/13/2020

LUIS ANDRE P. VIZCOCHO
Attorney for Respondents

ENDORSEMENT

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

DATED: 11/16/20

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
GREGORY J. SALUTE
Supervising Deputy Attorney General

STEPHEN A. ARONIS
Deputy Attorney General
Attorneys for Complainant

SD2019701887
82597067.docx

Exhibit A

Accusation No. 6777

XAVIER BECERRA
Attorney General of California
GREGORY J. SALUTE
Supervising Deputy Attorney General
STEPHEN A. ARONIS
Deputy Attorney General
State Bar No. 204995
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9451
Facsimile: (619) 645-2581
Attorneys for Complainant

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

In the Matter of the Accusation Against**:** **WALZAIN, INC.,** **DBA THE MEDICINE SHOPPE;** **ROUSL NABIL AL ROUBAE** **OWNER** **2939 Alta View Drive, Ste. L** **San Diego, CA 92139** **Pharmacy Permit No. PHY 55851,** **and** **ROUSL NABIL AL ROUBAE** **P.O. Box 1997** **Bonita, CA 91908** **Pharmacist License No. RPH 72775** Respondents.	Case No. 6777 **ACCUSATION**

PARTIES

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

2. On or about November 15, 2017, the Board of Pharmacy issued Pharmacy Permit Number PHY 55851 to Walzain, Inc., dba The Medicine Shoppe (Respondent The Medicine Shoppe). The Board's records reflect that Rousl Nabil Al Roubae owns all the outstanding shares of The Medicine Shoppe. The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on November 1, 2020, unless renewed.

3. On or about July 9, 2015, the Board of Pharmacy issued Pharmacist License Number RPH 72775 to Rousl Nabil Al Roubae (Respondent Roubae). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2021, unless renewed. At all times relevant to the allegations and charges herein, Respondent Roubae was the owner and pharmacist-in-charge of Respondent The Medicine Shoppe.

JURISDICTION

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

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

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

7. Section 4300, subdivision (a) of the Code provides that every license issued by the Board may be suspended or revoked.

8. 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.

STATUTORY PROVISIONS

9. Section 4022 of the Code states

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

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

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

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

10. Section 4113, subdivision (c) of the Code states:

The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws. and regulations pertaining to the practice of pharmacy.

11. Section 4301 of the Code states in pertinent part:

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

…

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

…

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

12. Sections 4306.5, subdivisions (a) and (b) of the Code state:

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

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

(b) Acts or omissions that involve, in whole or in part, the failure to exercise or

implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services.

13. Section 4307, subdivision (a) of the Code states that:

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 manger, administrator, owner, member, officer, director, associate, or partner had knowledge 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 manger, 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.

14. Health and Safety Code section 11153, subdivision (a) states:

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

15. Health and Safety Code section 11162.1, subdivision (a) states:

(a) The prescription forms for controlled substances shall be printed with the following features:

(1) A latent, repetitive 'void' pattern shall be printed across the entire front of the prescription blank; if a prescription is scanned or photocopied, the word "void" shall appear in a pattern across the entire front of the prescription.

(2) A watermark shall be printed on the backside of the prescription blank; the watermark shall consist of the words "California Security Prescription."

(3) A chemical void protection that prevents alteration by chemical washing.

(4) A feature printed in thermochromic ink.

(5) An area of opaque writing so that the writing disappears if the prescription is lightened.

(6) A description of the security features included on each prescription form.

(7) (A) Six quantity check off boxes shall be printed on the form so that the prescriber may indicate the quantity by checking the applicable box where the following quantities shall appear:

1-24
25-49
50-74
75-100
101-150
151 and over.

(B) In conjunction with the quantity boxes, a space shall be provided to designate the units referenced in the quantity boxes when the drug is not in tablet or capsule form.

(8) Prescription blanks shall contain a statement printed on the bottom of the prescription blank that the "Prescription is void if the number of drugs prescribed is not noted."

(9) The preprinted name, category of licensure, license number, federal controlled substance registration number, and address of the prescribing practitioner.

(10) Check boxes shall be printed on the form so that the prescriber may indicate the number of refills ordered.

(11) The date of origin of the prescription.

(12) A check box indicating the prescriber's order not to substitute.

(13) An identifying number assigned to the approved security printer by the Department of Justice.

(14) (A) A check box by the name of each prescriber when a prescription form lists multiple prescribers.

(B) Each prescriber who signs the prescription form shall identify himself or herself as the prescriber by checking the box by his or her name.

(b) Each batch of controlled substance prescription forms shall have the lot number printed on the form and each form within that batch shall be numbered sequentially beginning with the numeral one.

. . . .

16. Health and Safety Code section 11164 states:

Except as provided in Section 11167, no person shall prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for a controlled substance, unless it complies with the requirements of this section.

(a) Each prescription for a controlled substance classified in Schedule II, III, IV, or V, except as authorized by subdivision (b), shall be made on a controlled substance prescription form as specified in Section 11162.1 and shall meet the following requirements:

(1) The prescription shall be signed and dated by the prescriber in ink and shall contain the prescriber's address and telephone number; the name of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services; refill information, such as the number of refills ordered and whether the prescription is a first-time request or a refill; and the name, quantity, strength, and directions for use of the controlled substance prescribed.

(2) The prescription shall also contain the address of the person for whom the controlled substance is prescribed. If the prescriber does not specify this address on the prescription, the pharmacist filling the prescription or an employee acting under the direction of the pharmacist shall write or type the address on the prescription or maintain this information in a readily retrievable form in the pharmacy.

. . . .

REGULATORY PROVISIONS

17. Code of Federal Regulations, Title 21, section 1306.04, subdivision (a) states:

A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his 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. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

18. California Code of Regulations, title 16, section 1715.65 states in pertinent part:

(a) Every pharmacy, and every clinic licensed under sections 4180 or 4190 of the Business and Professions Code, shall perform periodic inventory and inventory reconciliation functions to detect and prevent the loss of controlled substances.

(b) The pharmacist-in-charge of a pharmacy or consultant pharmacist for a clinic shall review all inventory and inventory reconciliation reports taken, and establish and maintain secure methods to prevent losses of controlled drugs. Written policies and procedures shall be developed for performing the inventory reconciliation reports required by this section.

(c) A pharmacy or clinic shall compile an inventory reconciliation report of all federal Schedule II controlled substances at least every three months. This compilation shall require:

(1) A physical count, not an estimate, of all quantities of federal Schedule II controlled substances. The biennial inventory of controlled substances required by federal

law may serve as one of the mandated inventories under this section in the year where the federal biennial inventory is performed, provided the biennial inventory was taken no more than three months from the last inventory required by this section;

(2) A review of all acquisitions and dispositions of federal Schedule II controlled substances since the last inventory reconciliation report;

(3) A comparison of (1) and (2) to determine if there are any variances;

(4) All records used to compile each inventory reconciliation report shall be maintained in the pharmacy or clinic for at least three years in a readily retrievable form; and

(5) Possible causes of overages shall be identified in writing and incorporated into the inventory reconciliation report.

(d) A pharmacy or clinic shall report in writing identified losses and known causes to the board within 30 days of discovery unless the cause of the loss is theft, diversion, or self-use in which case the report shall be made within 14 days of discovery. If the pharmacy or clinic is unable to identify the cause of the loss, further investigation shall be undertaken to identify the cause and actions necessary to prevent additional losses of controlled substances.

(e) The inventory reconciliation report shall be dated and signed by the individual(s) performing the inventory, and countersigned by the pharmacist-in-charge or professional director (if a clinic) and be readily retrievable in the pharmacy or clinic for three years. A countersignature is not required if the pharmacist-in-charge or professional director personally completed the inventory reconciliation report.

…

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

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

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

COST RECOVERY

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

///

///

///

DRUGS

21. Norco, a brand name for hydrocodone and acetaminophen, is a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4), a Schedule II controlled substance pursuant to Code of Federal Regulations, title 21, section 1308.12, subdivision (b)(1)(vi), and is a dangerous drug pursuant to Business and Professions Code section 4022.

22. Percolone/Roxicodone are brand names for oxycodone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug pursuant to Business and Professions Code section 4022.

23. Percocet, a brand name for acetaminophen with oxycodone, is Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M), and is a dangerous drug pursuant to Business & Professions Code section 4022. Percocet is a combination of a narcotic and an analgesic/antipyretic used to treat moderate to moderately severe pain.

24. Phenergan with Codeine is the brand name for promethazine with codeine syrup, and is a Schedule V controlled substance pursuant to Health and Safety Code section 11058, subdivision (c)(1), and a dangerous drug pursuant to Business and Professions Code section 4022.

25. Tussionex Pennkinetic Suspension is the brand name for hydrocodone and chlorpheniramine, a cough syrup, and is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4), a Schedule II controlled substance pursuant to Code of Federal Regulations, title 21, section 1308.12, subdivision (b)(1)(vi), and a dangerous drug pursuant to Business and Professions Code section 4022.

26. Xanax is the brand name for alprazolam, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1), and a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

27. The Medicine Shoppe is an independent community pharmacy located in San Diego, California. At all times relevant to the allegations and charges herein, Respondent Roubae was

the owner and pharmacist-in-charge of Respondent The Medicine Shoppe (collectively Respondents).

28. Respondents had policies and procedures in place discussing the requirements of Health & Safety Code section 11153 and the Board's precedential decision, *In the Matter of the Accusation Against Pacifica Pharmacy; Thang Tran,* Board of Pharmacy Case No. 3802; OAH No. 2011010644; Precedential Decision No. 2013-01, effective August 9, 2013. The policies and procedures described red flags to investigate before filling controlled substance prescriptions--including the same diagnosis codes for many patients, multiple prescribers for the same patient for duplicate therapy, cash payments, and long distances traveled from the patients' residence to the pharmacy or from the prescriber to the pharmacy.[1] The policies and procedures also noted that a violation of the corresponding responsibility doctrine could subject a pharmacist to disciplinary action, including revocation of his or her license by the Board.

29. Based on her education and professional experience, Respondent Roubae knew that the starting dose for alprazolam in adults was 0.25 to 0.5mg, the starting dose for oxycodone immediate release in adults was 5-10mg, the starting dose for Norco in adults was 2.5-5mg, and the starting dose for promethazine with codeine in adults was 5mL.

30. Respondents ordered unusually large quantities of promethazine with codeine from their wholesaler, including 48 pints on December 14, 2017; 48 pints on January 10, 2018; 6 pints on January 16, 2018; 6 pints on January 24, 2018; and 48 pints on February 27, 2018. On January 11, 2018, Respondents' wholesaler submitted a Suspicious Order Report to the Board identifying the January 10, 2018 order of promethazine with codeine as suspicious.

31. After receipt of the wholesaler's report, on February 27, 2019, a Board of Pharmacy inspector conducted an inspection of Respondent The Medicine Shoppe. Respondent Roubae was present during the inspection. The Board's inspector determined that on numerous occasions,

[1] The policies and procedures provided that a patient located more than 5 miles from the pharmacy was a red flag, while Respondent Roubae told the Board inspector that a patient located more than 15 miles away from the pharmacy was a red flag. Her answer to a later questionnaire stated that a patient located more than 25 miles from the pharmacy was a red flag.

Respondents failed to exercise their corresponding responsibility and best professional judgment to dispense only medically-legitimate controlled substance prescriptions.

32. The inspector focused on 15 prescribers. The inspector found prescriptions containing significant irregularities and "red flags," suggesting that the prescriptions were not written or filled for a legitimate medical purpose. The prescribing profiles for all these prescribers were for numerous, repetitive prescriptions for commonly-abused controlled substances, in high doses, and with similar combinations of controlled substances dispensed in sequence to multiple patients. Most, if not all of the prescriptions from these prescribers exhibited obvious red flags of drug abuse that were ignored by the Respondents in filling them, in spite of the Respondents' corresponding responsibility to ensure that all prescriptions filled are for a legitimate medical purpose.

Those red flags included:

- Irregularities on the face of the prescriptions;
- Cash payments;
- Prescriptions written for an unusually large quantity of drugs;
- The same combinations of drugs prescribed for multiple patients;
- Initial prescriptions written for strong opiates;
- Long distances traveled from the patient's home to the prescriber's office or pharmacy.

33. From November 15, 2017 through February 27, 2019, Respondents Roubae and The Medicine Shoppe dispensed **367** prescriptions for controlled substances that were issued under the prescribing authority of 15 physicians. Respondents' prescribing profiles for these physicians indicated that promethazine with codeine and oxycodone 30mg, drugs associated with high rates of abuse and diversion, were the most commonly prescribed drugs for these physicians. **119** of the prescriptions were written on prescription forms that were not compliant with the requirements of the Health and Safety Code.

34. In connection with the aforementioned prescriptions, Respondents dispensed an aggregate total of approximately **115,906 mL, or 245 pints,** of promethazine/codeine, **7,385**

tablets of oxycodone 30mg, **6,570** tablets of Norco, **390** tablets of alprazolam 2mg, **115** mL of hydrocodone/chlorpheniramine, and **90** tablets of Percocet.

35. "Patients" paid for all of the 367 prescriptions in cash even though the majority of patients (89%) sought reimbursement from insurance companies or government agencies for prescriptions filled at Respondent The Medicine Shoppe during the time frame in question.

36. For Dr. N.K., from January 5, 2018 to March 26, 2018, Respondents dispensed 53 prescriptions for controlled substances. All of the controlled substance prescriptions written by Dr. N.K. and dispensed by Respondents were paid for with cash. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of just 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. In addition, the Medical Board listed Dr. N.K.'s area of specialty as anesthesiology and pain medicine on its website; it was a red flag for an anesthesiologist to prescribe promethazine with codeine because those specialists typically do not prescribe those drugs. Dr. N.K. also practiced in Hesperia and Corona, California, over 140 and 98 miles, respectively, away from Respondents' pharmacy practice in San Diego, California, another red flag. The top medication prescribed by Dr. N.K. was promethazine with codeine and for unusually high quantities (*i.e.*, 1 pint). Dr. N.K. prescribed the same combination of drugs (amoxicillin and promethazine with codeine) to multiple patients. This uniformity of treatment, both in general and on the same days, was a red flag of illegitimacy. Many of the prescriptions also involved high starting doses of these drugs, another red flag of illegitimacy. Respondents indicated they reviewed CURES that would have notified them of the high starting dosages for opiate-naïve[2] patients and Respondent Roubae was aware of the appropriate starting doses for controlled substances. Nevertheless, Respondents disregarded this information and filled these prescriptions.

Dr. N.K. also prescribed potential duplicative therapy with antitussive effects (*i.e.,* oxycodone or hydrocodone with promethazine with codeine). There were at least seven instances when one of these combinations was dispensed to one patient on the same day. This was a red

[2] An opiate naïve patient is one who has not taken opiate doses for one week or longer.

flag of illegitimacy. 44 of the prescriptions were written on non-compliant forms, in that they lacked the correct watermark. Multiple patients had the same local address listed on prescriptions, a red flag again. When patients picked up prescriptions, they presented identification cards with addresses different from the addresses on the prescriptions and significant distances from the pharmacy, including Perris (Patient D.J.L., 80 miles), Cherry Valley (Patients C.C. and N.C., 102 miles), Moreno Valley (Patient E.I., 96 miles), Banning (Patient C.B., 104 miles), Hemet (Patients J.P., M.W., and L.M., 87 miles) Azusa (Patient N.L., 122 miles), Grand Terrace (Patient K.J., 101 miles), Ontario (Patient L.J.T., 113 miles), Norwalk (Patient J.M., 106 miles) and Nuevo (Patient T.D.T., 83 miles). Three patients, C.C., K.J., and T.D.T., presented expired drivers' licenses when picking up prescriptions.

On January 22, 2018, Respondent Roubae noted that Dr. N.K. wrote prescription number 4955932 for promethazine with codeine for a "high level of codeine" but still filled that prescription. On January 26, 2018, Respondent Roubae wrote, "do not fill" on Prescription Number 2952042 written by Dr. N.K. She also wrote, "contact Dr. N.K." about that prescription because the prescription was for a "high quantity, high dose" of that controlled substance. Nonetheless, Respondents continued to fill 40 more prescriptions from Dr. N.K. (12 of which were for oxycodone and 13 of which were for promethazine with codeine).

Respondents did not contact Dr. N. K. to question and resolve the red flags of illegitimacy. Respondents dispensed numerous prescriptions from Dr. N.K. without ensuring they were for a legitimate medical use; when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed.

37. For Dr. E.C., from April 10, 2018 to April 13, 2018, Respondents dispensed five controlled substance prescriptions. Cash payments were made for all of these controlled substance prescriptions dispensed by Respondents. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of just 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. Dr. E.C. wrote promethazine with codeine prescriptions for unusually high quantities and the same combination of drugs (promethazine with codeine and amoxicillin) to multiple patients on the

same day. Respondents dispensed them on the same day with consecutive prescription numbers and within five minutes from each other. The controlled substance prescriptions were also dispensed from invalid forms in that they were missing security features required on controlled substance security prescription forms, including a watermark printed on the backside of the prescription blank that read "California Security Prescription," and a statement at the bottom missing the word "prescribed." Patients presented identification cards with different addresses than those on the prescriptions and located a significant distance from the pharmacy, including Perris (Patients R.R. and I.S., 80 miles), Moreno Valley (Patient E.M., 96 miles) and Canyon Lake (Patient E.S., 83 miles). Respondents dispensed prescriptions from Dr. E.C. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed. Respondents did not contact Dr. E.C. to question or resolve red flags of illegitimacy.

38. For Dr. M.C., from April 13, 2018, through June 8, 2018, Respondents dispensed 11 prescriptions for controlled substances. Cash payments were made for all of these prescriptions written by Dr. M.C. and dispensed by Respondents. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of just 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. Dr. M.C. practiced in Alhambra, located 122 miles away from the pharmacy, another red flag. The top medication prescribed by Dr. M.C. was promethazine with codeine, a commonly abused controlled substance in an unusually high amount (1 pint). Five of the prescriptions did not conform to the requirements of Health & Safety Code section 11162.1, in that they lacked a proper watermark and sequential form numbers. The addresses listed on the identification cards presented at time of furnishing were different from the addresses on the prescriptions and located significant distances from the pharmacy, including Murietta (Patient G.C., 65 miles), Sun City (Patient C.F., 75 miles), Moreno Valley (Paitent E.C., 96 miles), Hemet (Patient R.F., 87 miles) and Perris (Patient B.C., 80 miles). Respondents dispensed prescriptions from Dr. M.C. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of

irregularities and red flags of illegitimacy existed. Respondents did not contact Dr. M.C. to question or otherwise resolve the issues and red flags of illegitimacy.

39. For Dr. P.E., from June 15, 2018 through February 25, 2019, Respondents dispensed 36 prescriptions for controlled substances. Cash payments were made for all of these prescriptions written by Dr. P.E. and dispensed by Respondents. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of just 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. The top medication prescribed by Dr. P.E. was promethazine with codeine, a commonly abused drug in an unusually high amount (1 pint). In fact, all 29 prescriptions written for this medication were written for a quantity of 473 mL (16 ounces or 1 pint). Three of them were written on the same day (January 4, 2019), within one hour of each other. Six of the prescriptions did not conform to the requirements of Health & Safety Code section 11162.1, in that they lacked the correct watermark. The addresses listed on the identifications presented were different from the addresses on the prescriptions and significant distances from the pharmacy, including Compton (Patient C.S., 114 miles), Redlands (Patient D.S., 110 miles), Hemet (Patients L.M. and G.W., 87 miles), Moreno Valley (Patient T.A., 96 miles) and Chino (Patient C.S., 110 miles). Some of the prescriptions also involved high starting doses of these drugs, another red flag of illegitimacy. Respondents reviewed CURES reports that would have notified them of the high starting dosages for opiate-naïve patients and Respondent Roubae was aware of the starting doses for controlled substances. Nevertheless, Respondents disregarded this information and filled those prescriptions. This was a red flag. Dr. P.E. prescribed the same combination of drugs to multiple patients, another red flag. A prescription was dispensed months after the prescription was written (Prescription No. 2952253 on January 2, 2018, but not dispensed until June 25, 2018). Respondents dispensed this prescription for oxycodone 30mg written by Dr. P.E. when that same patient was dispensed the same prescription for oxycodone by two other physicians on January 24, 2018 and March 7, 2018. Respondents dispensed these prescriptions from Dr. P.E. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed.

40. For Dr. J.F., from January 16, 2018 to August 15, 2018, Respondents dispensed four prescriptions for controlled substances. Cash payments were made for all of these prescriptions written by Dr. J.F. and dispensed by Respondents. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of just 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. The Medical Board listed Dr. J.F.'s specialty as orthopedics; orthopedic surgeons do not typically prescribe promethazine with codeine. Hence, it was a red flag for Dr. J.F. to prescribe that medication (the prescriptions even listed Dr. J.F.'s surgery center). In fact, the top controlled medication prescribed by Dr. J.F. was promethazine with codeine, a commonly abused drug in an unusually high amount (1 pint). These were reds flag of illegitimacy. The location of Dr. J.F.'s primary practice on the Medical Board website was 116 miles away in Pomona and his secondary practice was located 64 miles away in Temecula, red flags. Respondents filled prescription number 4956032 on March 5, 2018, a month after Dr. J.F. wrote it. This was a factor of irregularity for a patient with a cough and infection to fill the prescription approximately a month later. Further, Dr. J.F.'s prescriptions did not conform to the requirements of Health & Safety Code section 11162.1, in that they lacked the proper watermark and an identifying number assigned to the approved security printer by the Department of Justice. When picking up the prescriptions, Patients presented identification cards with different addresses from the addresses on the prescriptions and significant distances from the pharmacy, including Perris (Patients B.C. and A.M., 80 miles), Hemet (Patient L.J., 87 miles) and Menifee (Patient D.B.T., 74 miles). Patient B.C. presented an expired driver's license at time of furnishing. Some of the prescriptions also involved high starting doses of these drugs for opioid-naïve patients, another red flag of illegitimacy. Respondents reviewed CURES reports that would have notified them of the high starting dosages for opiate- naïve patients and Respondent Roubae was aware of the appropriate starting doses for controlled substances. Nevertheless, Respondents disregarded this information and filled those prescriptions. Respondents dispensed prescriptions from Dr. J.F. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed.

41. For Dr. E.J., from June 14, 2018, and February 22, 2019, Respondents dispensed 43 controlled substance prescriptions. Cash payments were made for all of Dr. E.J.'s prescriptions dispensed by Respondents. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of just 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. The top medication prescribed by Dr. E.J. was promethazine with codeine, a commonly abused drug in unusually high quantities (1 pint), which were red flags of illegitimacy. Three prescriptions for promethazine with codeine in unusually large quantities were dispensed on the same day within one hour after the pharmacy closed. Four of the prescriptions were written on non-compliant forms, in that they lacked the proper watermark and sequential form numbers. When patients picked up their prescriptions, the identification cards presented listed addresses different from the addresses on the prescriptions and a significant distances from the pharmacy, including Hemet (Patient J.P., 87 miles), and Chino (Patient N.L., 109 miles). Some of the prescriptions also involved high starting doses of oxycodone for opioid-naïve patients, another red flag of illegitimacy. Respondents reviewed CURES reports that would have notified them of the high starting dosages for opiate-naïve patients and Respondent Roubae was aware of the appropriate starting doses for controlled substances. Nevertheless, Respondents dispensed those drugs. Respondents dispensed prescriptions from Dr. E.J. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed. Respondents did not contact Dr. E.J. to question or otherwise resolve the issues and red flags of illegitimacy.

42. For Dr. M.J., from January 11, 2018 to February 22, 2019, Respondents dispensed 40 controlled substances prescriptions. Cash payments were made for all of Dr. M.J.'s controlled substance prescriptions dispensed by Respondents. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of just 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. The top medication prescribed by Dr. M.J. was promethazine with codeine, a commonly abused drug in an unusually high quantity (1 pint), which were red flags of illegitimacy. On December 28,

2018, Respondents dispensed six of Dr. M.J.'s prescriptions for promethazine with codeine for a large quantity, within a 2 1/2-hour period, a red flag. Five of the prescriptions were written on non-compliant forms, including the wrong watermark and refill numbers to be circled, rather than check boxes for refills. When patients picked up prescriptions, they presented identification cards with addresses different from the addresses on the prescriptions and located significant distances from the pharmacy, including Moreno Valley (Patients B.S. and A.D., 96 miles), Hemet (Patient G.L.W., 87 miles) and Yucaipa (Patient S.M., 113 miles). Patients B.S. and A.D. had the same local address and prescriptions written for the same drug combinations on the same date by Dr. M.J. Respondents dispensed those prescriptions on the same day, despite the red flags of illegitimacy. Multiple patients had the same local address written on Dr. M.J.'s prescriptions, red flags again. Respondents dispensed prescriptions from Dr. M.J. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed. Respondents did not contact Dr. M.J. to question or otherwise resolve the issues and red flags of illegitimacy.

43. For Dr. K.K. from December 29, 2017 to August 28, 2018, Respondents dispensed 38 prescriptions for controlled substances. Cash payments were made for all of these prescriptions written by Dr. K.K. and dispensed by Respondents. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of just 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. The Medical Board website listed Dr. K.K.'s specialty as pediatrics; it was a red flag for a pediatrician to prescribe controlled substances and for a pediatrician to prescribing drugs to adult patients as done by Dr. K.K. The Medical Board website also listed Dr. K.K.'s address of record as being located in Yuma, Arizona, approximately 172 miles from the pharmacy. The top controlled medication prescribed by DR. K.K. was promethazine with codeine, a commonly abused drug in unusually high quantities (1 pint) which were red flags of illegitimacy. Dr. K.K. prescribed the same combination of drugs (promethazine with codeine and amoxicillin) to multiple patients. On the same day, Dr. K.K. wrote prescriptions and Respondents dispensed them within an hour to patients A.D., S.D. and B.S. Five of the prescriptions were written on non-compliant forms, in

that they lacked the correct watermark. When patients picked up the prescriptions, the addresses on identification cards presented were different from the addresses on the prescriptions and a significant distance from the pharmacy, including Hemet (Patient G.L.W., 87 miles), Long Beach (Patient S.D., 106 miles), Grand Terrace (Patient K.J., 101 miles), Moreno Valley (Patient A.D., 96 miles) and Banning (Patient C.B., 104 miles). Patients S.D. and K.J. presented expired driver's licenses at the time of dispensing, also red flags. Prescriptions also involved high starting doses of Norco, another red flag of illegitimacy. Respondents reviewed CURES reports that would have notified them of the high starting dosages for opiate-naïve patients and Respondent Roubae was aware of the appropriate starting doses for controlled substances but still dispensed high starting doses. Prescriptions listed the same local address for multiple patients, another red flag. Respondents dispensed prescriptions from Dr. K.K. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed. Respondents did not contact Dr. K.K. to question or otherwise resolve the issues and red flags of illegitimacy.

44. For Dr. A.K., from January 29, 2018 to March 5, 2018, Respondents dispensed seven prescriptions for controlled substances. Cash payments were made for all of these prescriptions written by Dr. A.K. and dispensed by Respondents. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. The top medication prescribed by Dr. A.K. was promethazine with codeine, a commonly abused drug in unusually high quantities (1 pint) which were red flags of illegitimacy. When they picked up prescriptions, patients' identification cards listed addresses different from the addresses on the prescriptions and a significant distance from the pharmacy, Moreno Valley (Patient L.E., 96 miles) and San Bernardino (Patient B.S., 107 miles). The city of San Bernardino was misspelled on one of the driver's licenses, another red flag. Respondents dispensed three prescriptions on non-compliant forms, in that they did not contain the appropriate watermark, an identifying number assigned to the approved security printer by the Department of Justice and lot numbers. Prescriptions also involved high starting doses of Norco, another red flag of illegitimacy to

opioid-naïve patients. Respondents reviewed CURES reports that would have notified them of the high starting dosages for opiate-naïve patients and Respondent Roubae was aware of the appropriate starting doses for controlled substances, but still dispensed the high starting doses. Respondents dispensed prescriptions from Dr. A.K. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed.

45. For Dr. J.L., from January 10, 2018 to January 30, 2018, Respondents dispensed six prescriptions for controlled substances. The Medical Board website listed Dr. J.L.'s specialty as pediatrics, a red flag in that pediatricians do not typically prescribe controlled substances. Dr. J.L. wrote controlled substance prescriptions to adults which was another red flag. Cash payments were made for all of these prescriptions written by Dr. J.L. and dispensed by Respondents. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of just 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. One of the medications prescribed by Dr. J.L. was promethazine with codeine, a commonly abused drug in unusually high quantities (1 pint) which were red flags of illegitimacy. Dr. J.L. prescribed the same combination of drugs (promethazine with codeine and amoxicillin) to multiple patients with the same address on the same day, red flags. Dr. J.L. prescribed both oxycodone and promethazine with codeine that has a potential for duplicative therapy of antitussive effects. When patients picked up prescriptions, they presented identification cards with addresses different from the addresses listed on the prescriptions and a significant distance away from the pharmacy, including Banning (Patient D.B., 104 miles), Rialto (Patient E.Y.M., 110 miles) and Moreno Valley (Patient O.B., 96 miles). Patients D.B. and O.B. presented expired driver's licenses. Four patients, D.B., E.Y.M., O.B., and J.H., had the same address listed on their driver's licenses. Five of the prescriptions were written on non-compliant forms, in that they lacked the appropriate watermark, an identifying number assigned to the approved security printer by the Department of Justice, sequential form numbers, and refill numbers to be circled rather than check boxes for refills. Respondents also dispensed a prescription for patient E.M. with a high starting dose of oxycodone, another red flag

of illegitimacy. Respondents reviewed CURES reports that would have notified them of the high starting dosages for opiate-naïve patients such as E.M and Respondent Roubae was aware of the appropriate starting doses for controlled substances. Nonetheless, they dispensed the prescription to that patient. Respondents dispensed prescriptions from Dr. J.L. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed.

46. For Dr. M.M., on January 11, 2018, Respondents dispensed two prescriptions for promethazine with codeine in an unusually high amount, a red flag. Cash payments were made for both of these prescriptions. The prescriptions identified Dr. M.M.'s practice areas as oncology and geriatrics but oncologists do not typically prescribe promethazine with codeine. Also, Dr. M.M. wrote the prescriptions for patients in their thirties, a red flag for a physician specializing in geriatrics. Dr. M.M. issued identical prescriptions for the same combination of drugs (amoxicillin and promethazine with codeine) to different patients on the same day (dispensed by Respondents on the same day). When patients picked up the prescriptions, they presented identification cards with addresses different from those on the prescriptions and a significant distance from the pharmacy, San Bernardino (Patient E.Q.S., 107 miles) and Apple Valley (Patient L.F.T., 154 miles). The city of San Bernardino listed on one of the identification cards was misspelled. The prescriptions were written on non-compliant forms, in that they lacked the appropriate watermark, sequential form numbers and an identifying number assigned to the approved security printer by the Department of Justice. Respondents dispensed prescriptions from Dr. M.M. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed.

47. For Dr. M.S., from January 5, 2018 to September 5, 2018, Respondents dispensed 38 prescriptions for controlled substances. Cash payments were made for all of these prescriptions written by Dr. M.S. and dispensed by Respondents. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of just 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. The top medication prescribed by Dr. M.S. was promethazine with codeine, a commonly abused drug

in an unusually high quantity (1 pint), many dispensed after hours, red flags of illegitimacy. When patients picked up their prescriptions, they presented identification cards with addresses different from those on the prescriptions and a significant distance from the pharmacy, including Winchester (Patient D.G., 78 miles), Banning (Patient C.B., 104 miles), Los Angeles (Patient J.R.H., 120 miles) and Richmond (Patient G.B., 500 miles). Patient J.R.H. presented an expired driver's license. Respondents also dispensed a prescription for patient T.G.D. with a high starting dose of oxycodone, another red flag of illegitimacy. Respondents reviewed CURES that would have notified them of the high starting dosages for opiate-naïve patient such as T.G.D and Respondent Roubae was aware of the appropriate starting doses for controlled substances. However, they still filled that prescription. Six of the prescriptions were dispensed on non-compliant forms, in that lacked the appropriate watermark and an identifying number assigned to the approved security printer by the Department of Justice. Respondents dispensed prescriptions from Dr. M.S. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed.

48. For Dr. R.S., from January 14, 2018 to February 24, 2018, Respondents dispensed 12 prescriptions for controlled substances. Cash payments were made for all of these prescriptions written by Dr. R.S. and dispensed by Respondents. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of just 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. The Medical Board identified Dr. R.S.'s specialties as neurology and sleep medicine. Neurologists do not typically prescribe promethazine with codeine and amoxicillin, Norco and oxycodone. Hence, it was a red flag for a neurologist to prescribe these drugs. The second most commonly prescribed medication by Dr. R.S. was promethazine with codeine, a commonly abused drug in unusually high quantities (1 pint). Respondents dispensed them after hours, red flags of illegitimacy. Dr. R.S. prescribed the same combination of drugs to multiple patients with the same address on the same day and Respondents dispensed them within minutes, other red flags. The prescriptions were written on non-compliant forms, in that a latent, repetitive void pattern was not printed across the entire front of the prescription blanks, the watermark was not correct,

and there were no sequential form numbers. When patients picked up prescriptions, they presented identification cards that listed addresses different from the addresses on the prescriptions and a significant distance from the pharmacy, including Ontario (Patients L.J.T. and L.M.A., 113 miles), Menifee (Patient D.B.T., 74 miles), Banning (Patient S.E.B., 104 miles), Quail Valley (Patient C.S., 81 miles), Perris (Patient R.B., 80 miles), Victorville (Patient S.T., 146 miles), Banning (Patient S.E.B., 104 miles), Highland (Patient J.J., 113 miles), Hemet (Patient J.D.G., 87 miles), Anaheim (Patient B.C.S., 95 miles) and Moreno Valley (Patient E.W.C., 96 miles). Patient L.M.A. presented an expired license at time of furnishing. Respondents also dispensed a prescription for patient D.B.T. with a high starting dose of oxycodone, another red flag of illegitimacy. Respondents reviewed CURES reports that would have notified them of the high starting dosages for opiate-naïve patients such as D.B.T. and Respondent Roubae was aware of the appropriate starting doses for controlled substances but still dispensed high starting doses. Respondents dispensed prescriptions from Dr. R.S. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed.

49. For Dr. K.S., from February 23, 2018 to January 4, 2019, Respondents dispensed 41 prescriptions for controlled substances. Cash payments were made for all of these prescriptions written by Dr. K.S. and dispensed by Respondents. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of just 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. The Medical Board website listed Dr. K.S.'s specialty as anesthesiology; anesthesiologists do no typically prescribe promethazine with codeine and amoxicillin. Hence, Dr. K.S.'s prescribing of those drugs was a red flag. The top medication prescribed by Dr. K.S. was promethazine with codeine, a commonly abused drug in unusually high quantities (1 pint). These were dispensed after hours, red flags of illegitimacy. Six of the prescriptions were written on non-compliant forms, in that the watermark was incorrect, there was no identifying lot numbers assigned to the approved security printer by the Department of Justice and there were no sequential form numbers. When patients picked up prescriptions, they presented identification cards with

addresses different from the addresses on the prescriptions and a significant distance from the pharmacy, including Los Angeles (Patient J.R.H., 120 miles), South Gate (Patient S.A.L., 119 miles), Hemet (Patient J.R., 87 miles), Glendora (Patient J.E.R., 120 miles) and Norwalk (Patient J.A.M., 106 miles). Patient J.R.H. presented an expired license at time of furnishing. Respondents also dispensed prescriptions with a high starting dose of oxycodone, another red flag of illegitimacy. Respondents reviewed CURES that would have notified them of the high starting dosages for opiate-naïve patients and Respondent Roubae was aware of the appropriate starting doses for controlled substances but still dispensed high starting doses still dispensed high starting doses.

On January 2, 2018, Respondent Roubae wrote, "[d]o not fill. Called Dr. [S.] for diagnosis code. High Quantity. High dose" on Dr. K.S.'s prescription for 120 tablets of oxycodone 30mg, acknowledging that 120 tablets of oxycodone 30mg was a high quantity and dose. Yet, Respondents dispensed approximately 65 more prescriptions under Dr. K.S.'s credential from February 23, 2018 through January 4, 2019. Respondents dispensed prescriptions from Dr. K.S. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed. Respondents did not contact Dr. K.S. to question or otherwise resolve the issues of red flags of illegitimacy.

50. For Dr. B.T., from January 12, 2018 to August 31, 2018, Respondents dispensed 31 prescriptions for controlled substances. Cash payments were made for all of these prescriptions written by Dr. B.T. and dispensed by Respondents. This disproportionate use of cash payments for these prescriptions was not consistent with the overall average cash payment rate of just 11% for drugs otherwise dispensed by Respondents, and was an obvious red flag for illegitimacy. The Medical Board website listed Dr. B.T.'s specialties as physical medicine and rehabilitation and sports medicine/pain medicine. These specialists do not typically prescribe promethazine with codeine and amoxicillin. Hence, Dr. B.T.'s prescriptions for those medications were red flags. The top medication prescribed by Dr. B.T. was promethazine with codeine, a commonly abused drug in unusually high quantities (1 pint), many of which Respondents dispensed after hours, red flags of illegitimacy. Six of the prescriptions were written on non-compliant forms, in that lacked

the appropriate watermark, an identifying number assigned to the approved security printer by the Department of Justice and sequential lot numbers.

When patients picked up prescriptions, they presented identification cards with addresses different from those on the prescriptions and a significant distance from the pharmacy, including Nuevo (Patient T.D.T., 83 miles), Long Beach (Patient S.A.L., 106 miles), Perris (Patient M.T., 80 miles) and Banning (Patient S.E.B., 104 miles). Patients T.D.T. and S.D. presented expired licenses. Respondents also dispensed prescriptions with a high starting dose of oxycodone to opioid-naïve patients, another red flag of illegitimacy. Respondents reviewed CURES reports that would have notified them of the high starting dosages for opiate-naïve patients and Respondent Roubae was aware of the appropriate starting doses for controlled substances but still dispensed the high starting doses. Respondents dispensed prescriptions from Dr. B.T. without ensuring they were for a legitimate medical use, when obvious, objective, and systemic signs of irregularities and red flags of illegitimacy existed. Respondents did not contact Dr. B.T. to question or otherwise resolve the issues and red flags of illegitimacy.

51. On or about January 24, 2018, Respondents did not dispense a pint of promethazine with codeine to patient S.B. per a prescription written by Dr. R.S. due to red flags. Yet, they dispensed one pint of promethazine with codeine to patient S.B. on April 3, 2018 per a prescription written by another physician, B.T. On May 1, 2018, they dispensed one pint of promethazine with codeine to patient S.B. per a prescription written by another physician, M.C.

52. From April 1, 2018 through February 27, 2019, Respondents did not compile inventory reconciliation reports of all federal Schedule II controlled substances, at least every three months.

FIRST CAUSE FOR DISCIPLINE

(Failing to Comply with Corresponding Responsibility for Controlled Substance Prescriptions)

53. Respondents are subject to disciplinary action under Code sections 4301, subdivisions (j) and (o), for violating Health and Safety Code section 11153, subdivision (a) and Code of Federal Regulations, Title 21, section 1306.04, subdivision (a), in that they failed to comply with

their corresponding responsibility to ensure that controlled substances were dispensed for a legitimate medical purpose. Respondents repeatedly furnished prescriptions for controlled substances even though obvious and systemic "red flags" were present to indicate those prescriptions were not issued for a legitimate medical purpose, as set forth in paragraphs 27 through 51 above, which are incorporated herein by reference.

SECOND CAUSE FOR DISCIPLINE

(Dispensing Controlled Substance Prescriptions with Significant Errors, Omissions, Irregularities, Uncertainties, Ambiguities or Alterations)

54. Respondents are subject to disciplinary action under Code section 4301, subdivision (o), for violating title 16, California Code of Regulations, sections 1761, subdivisions (a) and (b), in that they dispensed prescriptions for controlled substances, which contained significant errors, omissions, irregularities, uncertainties, ambiguities or alterations, as set forth in paragraphs 27 through 51 above, which are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Failing to Exercise or Implement Best Professional Judgment or Corresponding Responsibility when Dispensing Controlled Substances against Rousl Nabil Al Roubae)

55. Respondent Rousl Nabil Al Roubae is subject to disciplinary action under Code section 4301, subdivision (o), for violating Business and Professions Code section 4306.5, subdivisions (a) and (b), in that she failed to exercise or implement her best professional judgment or corresponding responsibility when dispensing controlled substances under circumstances with obvious red flags of illegitimacy, as set forth in paragraphs 27 through 51 above, which are incorporated herein by reference.

FOURTH CAUSE FOR DISCIPLINE

(Dispensing Controlled Substance Prescriptions Written on Unauthorized Forms)

56. Respondents are subject to disciplinary action under Code sections 4301, subdivisions (j) and (o), for violating Health and Safety Code section 11164, subdivision (a), in that they repeatedly filled and dispensed controlled substances from prescription forms that did not comply

with the requirements of Health and Safety Code section 11162.1, as set forth in paragraphs 27 through 51 above, which are incorporated herein by reference.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Compile Inventory Reconciliation Reports of all Federal Schedule II Controlled Substances)

57. Respondents are subject to disciplinary action under Code section 4301, subdivision (o), for violating California Code of Regulations, title 16, section 1715.65, subdivision (c) in that Respondents did not compile an inventory reconciliation reports of all federal Schedule II controlled substances at least every three months, as set forth in paragraph 52 above, which is incorporated herein by reference.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

58. Respondents are subject to disciplinary action under Code section 4301 for unprofessional conduct in that they engaged in the activities described in paragraphs 27 through 52 above, which are incorporated herein by reference.

OTHER MATTERS

59. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit No. PHY 55851 issued to Walzain, Inc. doing business as The Medicine Shoppe, it shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 55851 is placed on probation or until Pharmacy Permit Number PHY 55851 is reinstated if it is revoked.

60. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit No. PHY 55851 issued to Walzain, Inc. doing business as The Medicine Shoppe while Rousl Nabil Al Roubae has been an owner or manager and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Rousl Nabil Al Roubae shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 55851 is placed on probation or until Pharmacy Permit Number PHY 55851 is reinstated if it is revoked.

61. Pursuant to Code section 4307, if discipline is imposed on Pharmacist License No. RPH 72775 issued to Rousl Nabil Al Roubae, Rousl Nabil Al Roubae shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 72775 is placed on probation or until Pharmacist License Number RPH 72775 is reinstated if it is revoked.

PRAYER

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

1. Revoking or suspending Pharmacy Permit Number PHY 55851, issued to Walzain, Inc., dba The Medicine Shoppe;

2. Revoking or suspending Pharmacist License Number RPH 72775, issued to Rousl Nabil Al Roubae;

3. Prohibiting Walzain, Inc., dba The Medicine Shoppe from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 55851 is placed on probation or until Pharmacy Permit Number PHY 55851 is reinstated if Pharmacy Permit Number PHY 55851 issued to Walzain, Inc., dba The Medicine Shoppe is revoked;

4. Prohibiting Rousl Nabil Al Roubae from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 55851 is placed on probation or until Pharmacy Permit Number PHY 55851 is reinstated if Pharmacy Permit Number PHY 55851 issued to Walzain, Inc., dba The Medicine Shoppe is revoked;

5. Prohibiting Rousl Nabil Al Roubae from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 72775 is placed on probation or until Pharmacist License Number RPH 72775 is reinstated if Pharmacist License Number RPH 72775 issued to Rousl Nabil Al Roubae is revoked;

///

6. Ordering Walzain, Inc., dba The Medicine Shoppe and Rousl Nabil Al Roubae to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

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

DATED: March 26, 2020

ANNE SODERGREN
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
Complainant

SD2019701887
72092335.docx