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

In the Matter of the Accusation Against:

CHANG HO YOO, DBA PCH MEDICAL PHARMACY,

Pharmacy Permit No. PHY 44527;

CHANG HO YOO,

Pharmacist License No. RPH 42018;

and

SEUNG PIL SUN,

Pharmacist License No. RPH 72473;

Respondents

Agency Case No. 6826

OAH No. 2020020246

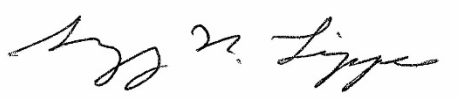
DECISION AND ORDER

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Pharmacy, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on January 20, 2021.

It is so ORDERED on December 21, 2020.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA



By

Greg Lippe
Board President

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PROPOSED DECISION

Eileen Cohn, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on August 10, 2020, via videoconference.

Stephanie J. Lee, Deputy Attorney General, represented Anne Sodergren (complainant), Interim Executive Officer of the Board of Pharmacy (Board), California Department of Consumer Affairs.

Herbert J. Weinberg, Attorney at Law, represented Seung Pil Sun .(respondent) who was present throughout the hearing.

Prior to the commencement of the hearing respondents Chang Ho Yoo dba PCH Medical Pharmacy (Yoo dba) and Chang Ho Yoo, individually (Yoo) entered into a Stipulated Settlement and Disciplinary Order with complainant subject to Board approval. In addition, Yoo entered into a Stipulated Settlement and Disciplinary Order for Public Reproval, subject to Board approval. As such, this hearing proceeded against respondent Sun only.

This matter had also been previously consolidated with two other matters by an order dated July 17, 2020 pursuant to Government Code section 11507.3: CNS Pharmacy, Inc., dba Caremax Pharmacy, Chang Ho Yoo, Case No 6855, OAH No. 2020070364, and CNS Pharmacy Inc. dba Caremax Pharmacy Inc. dba Caremax Pharmacy #4, Chang Ho Yoo, Case No. 6866, OAH No. 2020070365. Prior to the hearing respondents withdrew their defenses to those cases. At the outset of the hearing, complainant and respondent stipulated to hearing this matter alone and the order consolidating the cases was reversed.

Complainant withdrew Exhibits 2, 3, 4, 6, and 7 and resubmitted a revised Exhibit 7, which was marked and admitted. Complainant's Exhibits 5, 8 10,11,12, 13,14,15, 16, 17, 18, 19 ,20, 21, 22, 23, 24, 25, 26. and 27 were marked and admitted. Respondent withdrew Exhibits A, B, D, E and F. Exhibit C and Exhibit G were marked.

Exhibit C was admitted as administrative hearsay and Exhibit D was admitted as direct evidence.[1]

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on August 8, 2020.

Pursuant to the parties' stipulation, a Protective Order has been issued for Exhibits 24 through 26 and those exhibits have been placed under seal. During the hearing, respondent was ordered to resubmit a redacted Exhibit C, which contained confidential information of subscribing patients, but did not.

On September 8, 2020, the record was reopened so that respondent could redact the attachments to page one of Exhibit C, and complainant would have an opportunity to review the redaction and file any objections thereto. On September 22, 2020 the record was reclosed and the matter resubmitted.

SUMMARY

This dispute involves 60 prescriptions for 120 tablets of oxycodone 30mg, from one prescribing doctor, Dr. Annamalai Ashokan (Ashokan) between May 16, 2016 and December 6, 2016. Complainant's Accusation against respondent is based on what has been referred to as "corresponding responsibility," or the obligation of the pharmacist to remain alert to "red flags" that indicate that a prescription for a controlled substance may not be appropriate. Complainant emphasized several red flags,

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[1] All exhibits marked and admitted, whether or not mentioned in this decision were considered.

including the dosage of the prescription, the amount of prescriptions filled at once, the distance from the patient's homes to Yoo dba, failure to include notes confirming contact with Ashokan, and the irregularities in the prescription forms such as the absence of lot numbers and watermarks.

During the time period of the questionable prescriptions, respondent was a pharmacist at Yoo dba working under Yoo, the owner and pharmacist in charge (PIC). Respondent maintains that he performed his due diligence, most notably, by expressing his concerns to Yoo, the PIC, and receiving assurances from Yoo that he met with Ashokan, obtained additional documentation, including clinical notes of his prescriptions, and that the prescriptions were valid. Respondent also alerted Yoo a second time when he was informed by other pharmacists in the area that prescriptions from this same doctor's practice may not have been written by him. Yoo informed respondent that he met with the doctor a second time and was informed by the doctor that he was aware of the rumor and was conducting an informal investigation. After this second meeting between Ashokan and Yoo, respondent did not accept any further prescriptions for this doctor.

Based upon the unique circumstances of this case, and respondent's compelling evidence of mitigation and rehabilitation, only a Disciplinary Order for Public Reproval is required to protect the public.

Jurisdictional Matters

1. On March 19, 2015, the Board issued Pharmacist License Number RPH 72473 (the License) to respondent. The License was in force and effect at all times relevant to the charge. brought herein and will expire on July 31, 2020, unless renewed.

2. On December 6, 2019, complainant filed and served the Accusation against respondent and the other named parties. Respondent timely filed a Notice of Defense. All jurisdictional requirements have been satisfied for this matter to proceed to hearing.

Conduct Subject to Discipline

3. The Board's findings were the result of an investigation conducted by Noelle Randall (Randall), Board inspector, licensed by the State of California as a pharmacist since 2009. Randall has been an inspector with the Board since 2014. Before her tenure with the Board, she worked as a pharmacist and PIC. She had the necessary credentials and experience to conduct the inspection at issue in this dispute. (Exh. 27.)

4. Randall prepared a thorough report dated August 16, 2019, based upon: an analysis of pharmacy controlled substance dispensing data as reported by Yoo dba to the Controlled Substance Review and Evaluation System (CURES)[2], documentation

[2] California doctors and pharmacies must report to the California Department of Justice every schedule II, III and IV drug prescription that is written or dispensed within seven days. Pharmacies are required to do so under Health and Safety Code section 11165, subdivision (d). The information provided establishes the CURES database, which includes information about the drug dispensed, drug quantity and strength, patient name, address, prescriber name, and prescriber authorization number including Drug Enforcement Agency (DEA) number and prescription number. (Exh. 8; Precedential Decision No. 2013-01, Case No. 3802, OAH No. 201101064 (Precedential Decision).)

provided by Yoo dba from pharmacy records; her review of the track record of other pharmacists in the area with Ashokan's prescriptions; and the general protocols for prescribing. (Exh. 8.) Randall provided credible and knowledgeable testimony and the red flags, with certain exceptions described below, were supported by the documentation she reviewed. On cross-examination Randall was candid about the foundation for her opinions and admitted when adjustments were appropriate if her assumptions were wrong.

5. This dispute involves a narrow, four-month window of time between May 16, 2016 and December 6, 2016, of the three-year audit period covered in Randall's investigation of Yoo dba, May 16, 2016 through May 14, 2019. During the three-year audit period, including the four-month period in dispute, Yoo dba primarily prescribed non-controlled substances and the overall dispensing "trends" for Yoo dba "were not irregular for a retail pharmacy," Randall concluded. (Exh. 8.) The pharmacy averaged 148 prescriptions per day during the three-year audit.

6. Randall found irregularities with the prescriptions from Ashokan. During the entire audit period 57.63 percent of Ashokan's prescriptions, or 219 prescriptions, were for oxycodone, 30 mg. Between May 16, 2016 and December 6, 2016, oxycodone 30 mg was Ashokan's "most commonly prescribed medication, accounting for over 57 percent of [ ] Ashokan's total prescribing." (Exh. 8.)

7. During that four-month time period between May 16, 2016 and December 6, 2016, 48 patients received prescriptions from Ashokan, with "at least one prescription" for oxycodone. (Exh. 8.)

8. Oxycodone is the generic name for a pain relief medication and opioid. It is classified as a medication and requires a prescription, but its use has been

recognized as subject to widespread abuse. Ashokan prescribed the highest dosage of oxycodone (30mg). Oxycodone is a dangerous drug pursuant to Business and Professions Code (Business Code) section 4011 and a Schedule II controlled substance pursuant to Health and Safety code (Health Code) section 1105, subdivision (b)(1)(M).

9. Forty-eight patients who filled their prescriptions at Yoo dba were prescribed the highest dosage of oxycodone available, 30 milligrams (mgs). Each of the 48 patients received at least one prescription for oxycodone. The dosage prescribed was contrary to the standard practice of treating patients with the lowest effective dose to minimize risk, side effects and toxicity, beginning with the lowest dosage before increasing the dosage. It is standard practice to prescribe different dosages of oxycodone with consideration given to the patient's age, weight, severity of symptoms and interactions with their other medications. Dosages range from 5, 10, 15, 20, and 30 mgs. It was unusual for Randall to see patients uniformly being prescribed the highest dosage regardless of their age, severity of symptoms, tolerance for narcotics. Randall considered this "a factor of irregularity." (Exh. 8.)

10. Randall did not have data to determine the patient's stage of pain management at the time they received the highest dose of 30 mg. However, it was undisputed that oxycodone is a highly addictive and abused drug and that the general acceptable practice was to titrate the medication upward and not maintain the pain management therapy at the highest dosage. The data collected from dba Yoo about Ashokan's prescriptions and the number of prescriptions established a pattern of prescribing that was not consistent with acceptable medical practice.

11. Complainant's Accusation was motivated by the Board's concern for opioid abuse and the broader public policy to reduce the risk of pain medication, such as oxycodone because of its wide-scale abuse. The Board has published a brochure on

"corresponding responsibility" to inform pharmacists of their obligation to conduct a reasonable inquiry "whenever the pharmacists believes that a prescription may not have been written for a legitimate medical purpose." (Exh. 9.) While the prescribing doctor is required to properly prescribe and dispense controlled substances, the pharmacist has a corresponding responsibility to "ensure the prescription is legal." *(Ibid.*) (citing Health Code section 11153 and Precedential Decision No. 2013-01.[3])

12. In addition to the overall pattern of prescribing the highest dosage of oxycodone described above, which was a factor of irregularity, the Board found that 60 prescriptions it reviewed had what it called other objective factors of irregularity or "red flags," factors which should raise concerns to the pharmacist and if not resolved, should result in the pharmacist refusing to fill the prescription. (Exhibit 8; Accusation.)

13. One red flag highlighted in the Accusation and in Randall's investigation, were that multiple consecutive prescriptions for Ashokan's patients were processed in one day, often within minutes of each other as established by the consecutive numbering provided by the dispensing computer. Most of the patients received two

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[3] In the Board's Precedential Decision, (Case No. 3802, OAH No. 201101064), effective June 3, 2012, which involved a PIC and owner of a pharmacy and more extensive and pervasive omissions of judgment than presented here, the Administrative Law Judge concluded that whenever a pharmacist believes that a prescription may not have been written for a legitimate medical purpose, the pharmacist must inquire, and when the results of a reasonable inquiry do not overcome the pharmacist's concern about a prescription being written for a legitimate medical purpose, the pharmacist must not fill the prescription.

prescriptions totaling 120 tablets with one prescription for 90 tablets, and the next consecutively numbered prescription for 30 tablets.

(A) On May 23, 2016, between 3:17 p.m. and 3:35 p.m., eight prescriptions for four patients of Ashokan were filled. Of those eight prescriptions four were prescriptions for 120 tablets of 30 mg each of oxycodone.

(B) On May 31, 2016, between 2:42 p.m. and 3:27 p.m., 16 prescriptions for eight patients of Ashokan were processed. All eight patients received prescriptions for a total of 120 oxycodone 30 mg tablets.

(C) On August 22, 2016, between 3:11 p.m. and 4:27 p.m., 16 prescriptions for eight patients of Ashokan were processed. Each patient received a total of 120, 30 mg tablets of oxycodone.

(D) On October 26, 2016, between 12:35 p.m. and 3:55 p.m., 27 prescriptions of oxycodone, 30 mg tablets were processed for 14 patients of Ashokan with 13 patients receiving 120 tablets (often in two prescriptions) and one patent receiving a total of 150 tablets.

(E) On November 28, 2016, between 1 :49 p.m. and 4:22 p.m., 29 prescriptions for fifteen patients of Ashokan were processed for 120, 30 mg tablets of oxycodone.

14. Another red flag highlighted in the Accusation and the Board's report was the large distance between the patients' place of residence to the pharmacy. (Exhs. 17 and 19.) Of the 48 patients of Ashokan, 23 had addresses of record more than 20 miles away from Yoo dba, located in Long Beach, California. Together these 23

patients had 193 prescriptions filled at Yoo dba. These 23 patients travelled over 40 miles round trip in the Los Angeles area to fill these prescriptions.

15. The absence of required security features in the written prescriptions was another red flag identified in the Board's review and highlighted in the Accusation. Of 60 prescriptions for Oxycodone from Ashokan's patients, the lot number and a "California Security Prescription" watermark was missing, which the Board maintains should alone have invalidated the prescription because the absence of these features indicated the prescriptions were not legitimate. In addition, lot numbers were missing.

16. The Board's review of the written prescriptions also uncovered an inconsistency between the date the prescription was issued by Ashokan's office and the date the prescription was processed by Ashokan's office. Ashokan's office supplied seven prescriptions with an issuance date of September 27, 2016, but which he processed one day earlier, on September 26, 2016. As such, according the Board's report and the Accusation these prescriptions were invalid because they contained an incorrect issuance date, and this problem was another red flag which placed respondent on notice of the overall legitimacy of Ashokan's prescriptions.

17. Another red flag for the Board was the absence of any handwritten notations in the documentation for 60 oxycodone prescriptions reviewed referencing contacts between any pharmacist at Yoo dba and Ashokan to obtain additional information to confirm the validity of Ashokan's prescriptions.

18. Despite her admissions during direct examination, Randall insisted a prudent pharmacist would never fill prescriptions that were so riddled with this "unusual" combination of red flags which rendered them illegitimate. In her opinion, a reasonable pharmacist would first resolve each red flag before filling the prescription.

Finding no evidence that respondent did so, she concluded respondent violated his corresponding responsibility.

19. Randall's opinion did not change after reviewing the medical records of a particular patients respondent's counsel provided to her. (Exhs. 24-26, Exh. C.) She maintained that although the documents, including progress reports, were "helpful" as they verified the patients was seen at the doctor's office, they did not resolve the pattern of high dosage prescriptions for so many patients, or "go far enough to address whether the prescriptions were issued for a valid purpose, on valid forms." (Randall testimony.)

20. Randall's opinion remained unchanged even though Yoo, the PIC met with Ashokan on two occasions, at the behest of respondent. Randall conceded that meeting with the doctor "helps the pharmacist obtain important information." She considered it a "good step, but does not fulfill correspondent responsibility," as the visit is "not a substitute for evaluating each prescription and addressing the red flags for each prescription." (Randall testimony.)

21. Overall, Randall maintained that due to the number of irregularities her opinion about respondent's failure to fulfill his corresponding responsibility would not change even if she was presented with evidence that the prescriptions were filled for a legitimate medical reason. (Randall testimony.)

22. Randall provided candid testimony. During cross-examination, she readily admitted certain deficiencies in the foundation for her conclusions. During cross-examination, Randall admitted that she had not been provided some of the additional information to provide context for some of the red flags, particularly her reliance upon

the mileage between patient's homes and Yoo dba, and the application of certain labelling statutes to respondent's situation.

23. Randall did not determine whether the prescriptions were written by Ashokan. It was clear from her investigation that she focused on the deficits found in the documentation independent of the source of the prescriptions. She was unable to directly interview Ashokan because the doctor did not cooperate.

24. Randall conceded that the criteria for an acceptable prescription form for a controlled substance had changed over the last four years. She did not believe Ashokan was using a "previously approved" form with security features, particularly the watermark, which came into effect in 2016, and the unique security number, which was added after 2016. The new requirements for watermarks were delayed and suspended for a time. She maintained that the batch and lot number requirements did exist during the time respondent filled Ashokan's prescriptions. In this case the prescriptions lacked a lot number. She conceded that in the course of her inspections of other pharmacies, she encountered situations where pharmacists mistakenly filled prescriptions with this type of form which lacked these security features. Randall conceded that if respondent believed Ashokan was using a legal form, and unaware that the form was not an approved or legitimate form, he would not be able to recognize it as a red flag, and, as such, the form itself would not be a red flag.

25. Randall confirmed the number of suspect prescriptions for oxycodone was relatively small, especially when compared to the overall prescriptions issued at Yoo dba during the audit period. On average 148 prescriptions were filled each day, and only one of those daily prescriptions was for oxycodone.

26. Randall determined the processing of the prescriptions in a narrow time frame was a red flag from the documentation, not from her interview with respondent.

27. Randall was questioned on cross-examination about respondent's obligation not to obstruct a patient's efforts to fill a valid prescription, under Business Code section 733 and the potential for him to be subject to discipline for refusing to fill a prescription he understood to be valid. Randall agreed that the application of that Business Code section relied upon the pharmacist's judgment. Randall agreed that absent red flags respondent would not be in violation of his corresponding responsibility if he applied his training and expertise to issue the prescription.

28. Randall also modified her opinion that the distance from the pharmacy to the patient's home was a red flag. Based upon the evidence provided, dba Yoo was in a reasonable distance from Ashokan's office, only 2.9 miles. On cross-examination she conceded that a patient would travel longer distances to a specialist's office. Randall hypothesized from her experience that often the prescribing doctor would direct patients to a favorable pharmacy to patients because many pharmacies have refused to fill the doctor's prescriptions. She acknowledged also that many pharmacies today refused to fill prescriptions for oxycodone or any Schedule II drugs. Nevertheless, in her report she reviewed data from three other pharmacies near the Ashokan's office and not one of them had filled any prescriptions from Ashokan for any medications whereas dba Yoo had filled 380 prescriptions for Ashokan during the three-year audit period. As such, Randall's suspicion that Ashokan's patients were directed to dba Yoo was supported by the evidence.

Respondent's Evidence of Mitigation/Rehabilitation

29. Ashokan was not a general practitioner and was qualified to issue prescriptions for pain management. During the time period respondent was filling Ashokan's prescriptions for his patients, Ashokan was licensed in California as a medical doctor with no record of discipline, self-reported his practice as pain management, and was board certified by the American Board of Psychiatry and Neurology and the American Board of Anesthesiology.[4] (Exh. 8.)

30. Respondent was cooperative with Randall's investigation and aside from her incorrect designation of him as the PIC, he confirmed her summary of the statement he made to her in her investigative report.

> PIC Sun stated he was initially concerned about the legitimacy and appropriateness of Dr. Ashokan's prescriptions so the pharmacy owner, Chang-Ho Yoo (RPH 42018) went to Dr. Ashokan's office to meet him. During this meeting, RPH Yoo asked Dr. Ashokan to provide

[4] At the time of Randall's investigative report, Ashokan was subject to an interim suspension order barring him from practice in California as of June 5, 2019; a First Amended Accusation was filed on July 1, 2019. (Exh. 18.) As of November 2019, Ashokan had entered into a stipulated settlement with the Medical Board of California (Medical Board) and surrendered his license to practice medicine. Official notice is taken pursuant to Government Code section 11515 of the licensing information posted on the Medical Board's website.

additional documentation including clinical notes with his prescriptions.

Later, PIC Sun heard from other pharmacists in the area that there were prescriptions "getting out" of Dr. Ashokan' s office which were not actually prescribed by Dr. Ashokan. PIC Sun stated RPH Yoo went back to Dr. Ashokan's office to inform him about this rumor. PIC Sun said Dr. Ashokan told RPH Yoo he was aware of the issue and was conducting an internal investigation into the matter.

PIC Sun stated he no longer accepted Dr. Ashokan's prescriptions after the second meeting between RPH Yoo and Dr. Ashokan.

(Exh. 8.)

31. With certain exceptions described below, respondent did not dispute the evidence of irregularities. Instead, he provided compelling mitigating circumstances, the most important of which was his reliance on Yoo, the PIC and owner of Yoo dba. Yoo was effectively respondent's sponsor. Yoo dba was where respondent obtained his early training as a pharmacist, and as a foreign national, he was reliant upon You for his restricted Visa. His pressure to abide by Yoo's directives due to his restricted Visa, is not a mitigating circumstance, nor does it excuse respondent's independent responsibility for his conduct.

32. Respondent's reliance on Yoo as a PIC and for his supervision, especially due to his lack of experience working for any other pharmacist, supports his decision to defer to Yoo's advice and instructions. He did feel pressure because of his restricted

Visa to abide by Yoo, but he also believed he was right to defer to Yoo because of Yoo's decades of experience as a pharmacist, his position as PIC and his experience as an owner of multiple pharmacies, including dba Yoo. Respondent admitted "all those things came into play." (Respondent's testimony.)

33. Respondent provided sincere, heartfelt and credible testimony about his conduct, life circumstances, and rehabilitation. Respondent is from South Korea and attended a six-year program at Northeastern University to obtain his doctorate in pharmacy. Throughout his university years he remained in the United States on a student Visa. Upon graduation in May 2014 he required a sponsorship to remain in the United States to work and complete the required internship. Through a family referral, Yoo retained respondent as an unpaid intern two days after he graduated. Respondent worked for Yoo exclusively in many of the pharmacies Yoo owned. After his internship ended respondent obtained his pharmacy license and continued to work with Yoo. Prior to the four-month time period relevant to this dispute respondent had never worked for any other PIC other than Yoo.

34. During his testimony, respondent expanded on his interview with Randall. He did have concerns and questions about Ashokan's prescriptions for oxycodone. He had only been a licensed pharmacist for five months when he filled the challenged prescriptions; as such, he relied upon Yoo, the PIC.

35. In addition to speaking with Yoo, respondent called Ashokan's but was not able to speak with him personally. Respondent checked CURES to verify that the patients were not receiving oxycodone from other pharmacies. He checked the DEA website to make sure Ashokan was registered. Respondent required patients to deliver the prescriptions and pick up the prescriptions. He required patients to produce photographic identification before he provided them the prescriptions and he made

copies of the identification so that he could verify their identification the next time they filled a prescription. (Exh. C.) He asked each patient questions about his or her symptoms to determine whether oxycodone was needed. He observed them; for example, he noticed one patient's difficulty walking. He did not allow anyone else to pick up the prescriptions other than the patient. He asked each patient to transfer all their other prescriptions to dba Yoo so that he could make sure there were no contraindications or reactions between medications. Respondent also consulted with each patient upon release of their prescriptions. He rejected prescriptions too far from the boundaries of the pharmacy located in Long Beach. (Exh. B. and respondent's testimony.)[5]

36. When respondent reviewed Ashokan's prescriptions he did not see anything that would invalidate them. He admitted he may not have been aware of every required "A-Z" security feature at the time, but he "noticed" whether there was "void" mark by scanning the document. (Respondent's testimony.)

37. Respondent was reliant upon Yoo for guidance and supervision. Yoo had thirty years of experience and he was just licensed for five months. During the four-month period at issue, he stated he was "just" a floor pharmacist. He was floating between Yoo's pharmacies and had only Yoo to rely upon for guidance. During the

[5] It was not entirely clear from respondent's testimony whether, aside from the geographical restraints, all these practices were instituted at the same time and from the beginning. Respondent testified on cross-examination that after Yoo's first visit he required the patients to bring all medications to dba Yoo.

relevant time period he was filling most prescriptions at Yoo dba, not just Ashokan's. (Respondent's testimony.)

38. Respondent admitted he was naïve at the time he filled Ashokan's prescriptions. He became suspicious because he knew oxycodone was an addictive drug and he had general questions (not clearly specified in his testimony) about the form prescriptions. (Respondent's testimony.)

39. Respondent attempted to speak with Ashokan but was only able to reach the "front-desk" personnel to verify the prescriptions. Respondent urged Yoo to talk to Ashokan and to get the progress notes, also known as "sub" notes to confirm what the patient's treatment and why oxycodone was prescribed. Respondent did not recall the details of Yoo's assurances, particularly about the missing security information on the prescriptions, but Yoo assured him after the visit that Ashokan was a legitimate doctor, and that progress notes would be provided. Respondent provided notes for three patients. (Exhs. 24-26 and respondent's testimony.)

40. Respondent estimated that Yoo's first visit with Ashokan occurred in mid-2015. After that visit, Yoo gave him the "green light" to fill Ashokan's oxycodone prescriptions. Respondent did not have all his questions answered, but he deferred to Yoo's experience and authority as a PIC. (Respondent's testimony.)

41. After the first visit, in the course of obtaining the patients' prescriptions from other pharmacies, respondent became aware that other pharmacies would not fill Ashokan's prescriptions for oxycodone. Pharmacists he spoke with said Ashokan was "not legitimate." By that time, respondent stated he had gained more experience and took the pharmacists' warnings seriously. (Respondent's testimony.)

42. Respondent provided convincing testimony for his choice to fill prescriptions all at once, which established that he was not filling them together in a manner that was outside the standard of care. Dba Yoo had been the victim of at least one burglary at the time respondent filled the prescriptions identified in Factual Finding 13, one in mid-2015, and another one in either late 2015 or early 2016. He intentionally filled the prescriptions he received, within a window of one to three days of receipt of the prescriptions, together, by blocking out a time when the pharmacy was slow, and he could completely focus on the prescriptions for oxycodone. He would type and print the labels, log the count, and put the oxycodone back in its secured cabinet. (Respondent's testimony.)

43. Within six to eight months of Yoo's first visit, respondent urged Yoo to visit with Ashokan a second time based upon the warnings he received from other pharmacists. After Yoo's second visit, respondent stopped filling prescriptions "cold turkey." (Respondent's testimony.)

44. In hindsight, respondent is not "proud" of his involvement with Ashokan's prescriptions. At some time after the four-month period, not clearly established by the record, respondent was elevated to PIC. There is no evidence that his conduct as PIC was anything other than professional. Respondent left dba Yoo in June 2019 without a new job to get away from Yoo and did not work for four months. By the time respondent left Yoo's employee he had gained more insight into Yoo's business practices and realized he relied too much on narcotics prescriptions, that Yoo failed to provide him proper instruction and oversight, and as a result, respondent was highly depended on advice from colleagues in the profession. As Yoo had been his sponsor and first employer it took a lot of "courage" for him to speak up and

challenge him, but eventually he took a chance and left his employ. (Respondent's testimony.)

45. Respondent is currently working as a licensed pharmacist for another pharmacy and has recently married. Respondent's practices have changed. He now routinely and independently from the PIC contacts and speaks with the doctors, and in addition to the diagnosis code, inquires about what treatment worked and did not work.

46. Respondent took the charges against him seriously and participated in a continuing education course that addressed corresponding responsibility.

47. Respondent provided persuasive character evidence from individuals who have had the opportunity to observe him or work with him in the community.[6]

48. Salida Nhean, licensed by the Board as a pharmacy technician, executed a personal statement dated July 30, 2019. Nhean worked at dba Yoo from 2007 through the date of the statement and observed respondent consult patients and review their profiles before he filled their prescriptions for controlled substances. Nhean also stated that respondent "always" obtained CURES reports for controlled substances, and "sometimes denied filling prescriptions for controlled substances when he did not feel comfortable filling certain prescriptions." (Exh. G.) The statement did not directly

[6] Salida Nhean's letter was admitted as direct evidence Other character evidence supported and explained respondent's testimony and was , admitted as administrative hearsay.

address the violations in the Accusation but did provide some foundation to measure respondent's rehabilitation.

49. Jihye Kim McCann, a Board-licensed pharmacist prepared a character reference letter dated February 2, 2020, based upon his knowledge of the Accusation. McCann provided some history of respondent's early working relationship with Yoo because they met in 2014 after respondent obtained his pharmacy degree and began his work as an intern with Yoo. McCann began one month after respondent at Caremax#2, where Yoo was a co-owner. McCann credited respondent with providing him training in the "entire pharmacy operation" and using the computer programs. (Exh. H-1, pp. 134-35.) Even though time working in the same location was relatively short they remained in contact and shared information until McCann resigned in July 2017. McCann had high praise for respondent's performance as a PIC.

> Philip is one of the most responsible and hard working pharmacist[s] I've ever known. After he moved to the PHC pharmacy and started working as a PIC, Mr. Yoo assigned him as a designated [person] who takes care of all insurance contracts and documentation issues for not just PCH pharmacy, but the entire Western medical company. Anytime we had an issue with Medical or other insurance company, he's the one who contacts them and solve[s] the issue. He was doing all this paper[work] on top of his regular pharmacist duties but he never complained or refused to do work for other pharmac[ies]. He sometimes came to the pharmacy hours before the pharmacy open[ed] or stayed after closing to finish these extra works. Although

> it was an assigned job, he always tried to help other co-workers sincerely when they needed him. Of course he was very well rounded and always maintained a very good relationship with other pharmacists and technicians. All of his co-workers appreciated his hard work[] and humble attitude. . . . [¶]. Also, he showed very good communication skills during patient consultation and truly tried to listen to his patients. There were lots of elderly Korean speaking patients who are not good at English. Philip sometimes helped them when they need a translation as well. I had a chance to work at PHC pharmacy during his honeymoon vacation and lots of patients [were] looking for Philip since he knows all his patients really well and takes care of them sincerely. Lots of patients told me he's an excellent pharmacist and they appreciate his help.

[Exh. H-1, pp. 133-134.]

50. McCann closed his letter with his conviction that, despite the Accusation, respondent remains a committed, "compassionate," "hardworking" and "intelligent" dedicated pharmacist with a "strong sense of responsibility." (Exh. H-1, p. 135)

51. Yuan Jeanie Son, a Board-licensed pharmacist and a licensee of the State of Maryland, wrote a character reference dated January 31, 2020. (Exh. H-2, pp. 136-137.) At the time of the reference letter, Son was working as a PIC for one of Yoo's pharmacies and had known and worked with respondent for four years. Son recommended respondent as someone "very knowledgeable about the overall management of the pharmacy" and as a "go-to" person for any problems from

pharmacists working in any of Yoo's pharmacies. She acknowledged Yoo's reliance on respondent's professionalism and his capable management of the myriad of insurance issues that arose, including a lost medical reimbursement check. She noted respondent's "great reputation among coworkers including pharmacists and technicians. We all respected him for his work ethic and mature attitude even though he was one of the youngest colleagues." (*Ibid.*) She emphasized respondent's "empathy, kindness and deepest patience." (*Id.*) Based upon her personal knowledge of respondent, she insisted any mistakes respondent made which gave rise to the Accusation "were not malevolent or malicious." *(Id.*).

52. Eun Hae Jung, a Board-licensed pharmacist, wrote a letter dated January 21, 2020. Jung worked with respondent at Caremax Pharmacy#4, owned by Yoo, for three years as of the date of her January 31, 2020 letter, and served as a graduate intern for 10 months prior to that time. She reiterated the comments of the other pharmacists about respondent's character, knowledge and professionalism, his hard work, patience and time spent resolving problems and providing guidance, and his understanding of overall pharmacy management. She stated: "[o]n behalf of all the other pharmacists who worked for Mr. Chang Yoo, I can say that we always looked up to Philip to help us with pharmacy issues and questions we had." (*Ibid.*) She hoped the Board would consider his "true character" and his passion about his pharmacy career. (*Id.*)

53. Mayra Mendoza, whose position was not specified, in a letter dated January 31, 2020, has worked with respondent since 2014 when he was first hired by Yoo and also observed him to be knowledgeable, hard-working, a "great listener and communicator," with the "kindest and warmest heart" who "shares his empathy and patience with everyone." She was aware of the Accusation and did not consider

respondent's conduct to be intentional. She hoped for a good outcome especially in view of the "young time" of his career and marriage, (Exh. H-4, pp. 139-140.)

Costs of Investigation and Prosecution

54. Complainant provided costs of investigation and prosecution through August 4, 2020. (Exh. 7., Decl. of Stephanie J. Lee.) The total cost of prosecution of the consolidated matter is $10,230 through June 26, 2020. (Exh.7, exh. A.) The total cost of investigation is $5.868.50 which consisted of Noelle Randall's investigation. (Exh. 7, Randall Decl.) The total costs of prosecution and investigation for the Accusation are 16,098.50. Complainant has requested the cost of prosecution and investigation be reduced by fifty percent because the Accusation also included Yoo, individually and acting through dba Yoo, prior to Yoo's settlement and withdrawal of the Notice of Defense. As such, complainant attributes to respondent $2,934.25 as his share of the total costs of investigation and $5,115 as his share of the total costs of prosecution and investigation, or $8, 049.25. The total costs for all parties are reasonable, especially since the cost of prosecution excludes attorneys' fees associated with the hearing.

55. Respondent provided testimony of the financial challenges he faced as an intern and pharmacist working for Yoo. He was an unpaid intern and worked an hourly wage thereafter and was not paid consistently. As the PIC and owner Yoo was responsible for the entire operation of his pharmacy and it is reasonable for him to pay at a minimum, the entire costs of investigation of his pharmacy, and for respondent to pay a portion of the attorneys' fees. For these reasons, respondent will not be charged with the cost of Randall's investigation. Respondent shall be responsible for one-half the cost of prosecution or $5,115.

LEGAL CONCLUSIONS

1. Business Code section 4300, subdivision (a), the Board may suspend or revoke a license or registration. Business Code section 4011 provides that the Board shall administer and enforce both the Pharmacy Law (Code sections 4000 *et seq*.) and the Uniform Substances Act (Health Code sections 11000 *et seq*.).

2. Code section 4301 states, in pertinent part, that the Board shall take action against any holder of a license who is guilty of unprofessional conduct, which includes, but is not limited to the following:

> [¶]. . .[¶]
>
> (d) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 1153 of the Health and Safety Code.
>
> [¶]. . .[¶]
>
> (j) The violation of any of the statutes of this state, of any other state, or of the United States regulating controlled substances and dangerous drugs.
>
> [¶]. . .[¶]
>
> (o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of this chapter or of the applicable federal and state laws and regulations governing

pharmacy, including regulations established by the board or by any other state or federal.

3. This dispute involves prescriptions for oxycodone, and opioid pain medication that have been classified as a Schedule II controlled substance pursuant to Health Code section 11055, subdivision (b)(1)(M), and a dangerous drug pursuant to Business Code section 4022.

4. Health Code section 4306.5 provides that:

> Unprofessional conduct for a pharmacist may include any of the following:
>
> [¶]. . .[¶]
>
> (b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services.

5. Health Code section 1153, subdivision (a) provides that prescriptions for controlled substances shall only be issued by medical professionals acting in the usual course of their professional practice. That section also states that the "responsibility for the proper prescribing and dispensing of controlled substance upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription."

6. Health Code section 1162.1, subdivision (a) requires specific features for prescription forms used for controlled substances, including (2) a watermark on the backside of the prescription blank with the words "California Security Prescription." Subdivision (b) requires that each "batch of controlled substance prescription forms shall have the lot number printed on the form and each form within the batch shall be numbered sequentially beginning with the numeral one.

7. Health Code section 1164 subdivision (a) provides that each prescription for a Schedule II, III, IV or V controlled substance, with certain exceptions, not applicable to this dispute, must be on prescription forms specified in Code section 1162.1.

8. California Code of Regulations, title 16 (Regulations), section 1761, subdivision (a) prohibits pharmacists from "dispensing any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration." The pharmacist requires the pharmacist to contact the prescriber to obtain the information needed to validate the prescription." Regulations, section 1761, subdivision (b), prohibits the pharmacist from dispensing a controlled substance "[e]ven after conferring with the prescriber,"…[¶]"where the pharmacist knows or has reason to know that said prescription was not issued for a legitimate medical purpose."

Cause

9. Complainant provided clear and convincing evidence that respondent failed to meet his corresponding responsibility, (first cause for discipline) and filled and dispensed improper prescriptions for controlled substances (second cause for discipline) as set forth in Factual Findings 3-43, and Legal Conclusions 2-8, for many, but not all, the deficiencies Randall found in her report.

(a) Complainant failed to prove by clear and convincing evidence that the absence of the watermark was a problem, given the possible delays in the requirement of a watermark and the lack of uniform usage of the watermark in Randall's review of other pharmacies. Complainant also failed to prove by clear and convincing evidence that the geographic distance from the patients' homes to the pharmacy was a red flag given the relative proximity of Ashokan's office to dba Yoo. Complainant also failed to prove by clear and convincing evidence that the short time intervals between respondent's processing of each prescription established his knowledge of the invalidity of the prescriptions.

(b) Nevertheless, there were major red flags which compelled a reasonable pharmacist to doubt the legitimacy of the prescriptions including Ashokan's pattern of exclusively prescribing a uniform and consistent prescription for the highest dosage of oxycodone, and the absence of a lot number. In addition, prescriptions for seven patients were filled even though the prescriptions were dated one day after the were filled. This last defect was a violation of Code of Federal Regulations, section 1306.05 which requires prescriptions to be "dates as of, and signed on, the day when issued.

(c) More significantly, the evidence established that despite respondent's attempts to validate that the prescriptions were issued for legitimate medical reasons, he never reached Ashokan, and issued the prescriptions anyway. The prescriptions did not contain notes of any contact. Although respondent produced some records for certain patients, overall there were inadequate records for all the patients at the time they were prescribed the highest dosage of oxycodone. Further, although respondent may have had a good reason to process multiple prescriptions within a short range of time, by doing so he had a unique opportunity to notice any

patterns of irregularity including the consistent high dosage without adequate documentation and missing lot numbers.

(d) Respondent admitted he was concerned with the prescriptions from Ashokan and did try to contact him, but never reached him. It was unclear from his testimony what deficiencies he recognized in the forms which compelled him to urge Yoo to contact Ashokan directly, because Ashokan was not responsive to him.

10. Respondent claims he was naïve and did not knowingly or intentionally fill invalid prescriptions, and that he was right to rely upon the PIC and owner Yoo. To further support he refers to his obligation to fill a prescription he understood to be valid pursuant to Business Code 733. However, respondent was suspicious of the Ashokan's prescriptions and his lack of experience and reliance on his PIC, under the express language of the governing law, does not discharge his corresponding responsibility. Respondent was still obligated to make a reasonable inquiry before dispensing oxycodone and that inquiry does not violate his obligation to fill a valid prescription. (See Precedential Decision, page 37, paragraph 11.) Randall agreed that absent red flags respondent would not be in violation of his corresponding responsibility if he applied his training and expertise to fill the prescription.

11. Respondent maintains that he satisfied his obligation to make a reasonable inquiry prior to filling the prescriptions, mainly by reasonably relying on Yoo, the PIC, for validation from Ashokan. Respondent maintains it was reasonable for him to rely on Yoo because of his extensive experience and because Yoo, as the PIC, was responsible for the conduct of the pharmacists. (*Sternberg v. California State Board of Pharmacy (*2015) 239 Cal.App.4th 1159.) In addition, respondent did make efforts to confirm the patient's identity, medical need for oxycodone from the patients and reviewed CURES. Nevertheless, his exclusive reliance on Yoo for validation from

Ashokan was not entirely sufficient to discharge his independent corresponding responsibility given the high dosage and the absence of evidence of clear medical records and sub notes for all patients. Respondents reliance of Yoo and his own conduct are factors in mitigation, but do not alter the foundation for his corresponding responsibility. Under the circumstances, respondent was required to refuse to fill the prescriptions.

Disposition

12. Administrative proceedings to revoke, suspend or impose discipline on a professional license are non-criminal and non-penal; they are not intended to punish the licensee, but rather to protect the public. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 785-786.

13. Once cause for discipline was established in this case, the level of discipline to be imposed on respondent must be determined. Such cause may be overcome with substantial, persuasive evidence of rehabilitation and good character. In reaching a decision on disciplining a licensee, the Board's Disciplinary Guidelines [Rev. 2/2017] (Guidelines) are to be considered. (Cal. Code Regs, tit. 16, § 1760.) The Guidelines divide the various types of violations into four categories, ranging from the least serious, Category I, to the most serious, Category IV. The Guidelines state "[t]hese categories assume a single violation. For multiple violations, the appropriate penalty shall increase accordingly." (Guidelines, p. 5.) If there are violations in more than one category, "the minimum and maximum penalties shall be those recommended in the highest category." (*Ibid*.) Here, based upon the circumstances of the case, respondent's violations are within Category II and relate to his corresponding responsibility.

14. The Board has compiled a list of factors which are contained in the Guidelines to evaluate whether a licensee has been rehabilitated from prior misconduct, and include: the nature and severity of the act under consideration; the actual or potential harm to any consumer or to the public; a licensee's prior disciplinary record; aggravating evidence; rehabilitation evidence; the licensee's compliance with the terms of any sentence, probation, or parole; the time that has elapsed since commission of the act; and evidence of dismissal of any conviction under Penal Code section 1203.4.

15. Complainant requests respondent's license be revoked or if revocation is not warranted by the evidence, revocation stayed, with the maximum probation for respondent, five years based upon two causes related to violations of his corresponding responsibility. In this case, the gravity of respondents' violations emanates from Category II and because this case involves the dispensing of dangerous drugs, the five years is recommended.

16. The unique circumstances of this case support a departure from the recommended five-year probation. Respondent made mistakes and these mistakes were compounded by the well-recognized prevalence of drug abuse associated with the distribution of oxycodone. There was no evidence any individual was harmed by the prescriptions, but nevertheless respondent's mistakes had the potential for great harm to the public.

17. Respondent provided substantial and compelling evidence of mitigating circumstances and rehabilitation for his mistakes. Respondent's conduct was restricted to a narrow period of time and involved a relatively small number of prescriptions he issued in the pharmacy of the 148 prescriptions a day. There is no evidence that respondent prescribed oxycodone for personal financial gain or received any other

personal benefit from his prescriptions. On the contrary, it was clear respondent was trying to do his job to the best of his ability and relied to his detriment primarily on the go-ahead of his PIC He attempted to do everything within his power by his direct contact with the patients, by his search of CURES and the DEA data base, and by urging his PIC, not once but twice to speak with Ashokan. The PIC was also the pharmacy owner and his mentor and was in the best position to obtain the necessary documentation. Notably, respondent stopped filling prescriptions for Ashokan's patients after he gained more experience and heard reports from other area pharmacists. At his urging, the PIC met with Ashokan a second time.

18. Respondent has an excellent reputation among his colleagues and co-workers. He was elevated to PIC and aside from the prescriptions filled from Ashokan during a four-month period of time, there is no evidence of any deficiencies in his practice. He is now working for another pharmacy, newly married and hoping to continue as a pharmacist. He has changed his practices. (Factual Findings 29-53.)

19. Respondent regrets his mistakes. He has participated in an educational program on corresponding responsibility. Rehabilitation is a "state of mind" and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.) Acknowledgement of the wrongfulness of one's actions is an essential step toward rehabilitation. (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933.)

20. Based upon the unique circumstances of this matter, and respondent's evidence of mitigation and rehabilitation public protection only requires Public Reproval. Respondent is a well-respected and knowledgeable pharmacist, who has been relied upon for advice from his peers. Other than the four-month period where respondent was filling prescriptions for oxycodone from Ashokan, respondent has a

record of superior performance. He has participated in continuing education. There is insufficient evidence to support restricting respondent's practice.

Costs

21. Under section 125.3, the Board may request the administrative law judge to direct a licentiate found to have committed violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. In *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court considered whether a similar cost recovery provision impermissibly discouraged licensees from exercising their due process rights to a hearing before their licenses could be revoked or suspended. The Court determined that cost recovery for investigation and prosecution is permissible as long as certain conditions are met: assessment of the costs will not unfairly penalize licensees who are found to have committed some wrongdoing but have used the hearing process to reduce the charges or the severity of the discipline; licensees have a subjective belief in the merits of their position; licensees have the means to pay the costs; and the costs are not disproportionally large when considered in the context of the innocuousness of the charge at issue. (*Zuckerman*, 29 Cal.4th at p. 45.)

22. The Board's costs of investigation and prosecution for the entire matter are reasonable. The Board has also reduced this respondent's costs of investigation and prosecution by half, apportioning the amount between respondent and Yoo, the PIC and owner of dba Yoo. However, as set forth in Factual Findings 53-54, while it is reasonable to apportion fifty percent of the cost of prosecution to respondent especially because the cost of prosecution does not include any legal fees associated with the hearing, the costs of investigation should be the entire responsibility of the Yoo individually and dba Yoo. This result is supported by the *Zuckerman* factors and

the overall responsibility of Yoo as owner and PIC, with strict liability for respondent's conduct. (See *Sternberg v. California State Board of Pharmacy (2015)* 239 Cal.App.4th 1159.) With regard to the *Zuckerman* factors, respondent presented his case in good faith and received a reduced discipline than that recommended by the complainant. There is no evidence that respondent benefitted financially from his mistakes; on the contrary, respondent experienced some financial difficulties during his tenure with Yoo. Respondent shall be required to reimburse the Board for $5,115 within 30 days of the effective date of this decision.

ORDER

1. It is hereby ordered that a Public Reproval be issued against licensee Seung Pil Sun, RPH 72473.

2. Respondent is required to report this Public Reproval as a disciplinary action.

3. Within 30 days of the effective date of this decision, or on a payment plan approved by the Board, respondent shall reimburse the Board in the amount of $5,115.

DATE: October 26, 2020

DocuSigned by:
Eileen Cohn
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EILEEN COHN
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the Accusation Against**:** **CHANG HO YOO, DBA PCH MEDICAL PHARMACY** 306 E. Pacific Coast Hwy, 101 Long Beach, CA 90806 **Pharmacy Permit No. PHY 44527,** **CHANG HO YOO** 20509 Bind Court Walnut, CA 91789 **Pharmacist License No. RPH 42018,** **and** **SEUNG PIL SUN** 839 Lorraine Blvd. Los Angeles, CA 90005 **Pharmacist License No. RPH 72473** Respondents.	Case No. 6826 **ACCUSATION**

PARTIES

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

2. On or about January 13, 2000, the Board of Pharmacy issued Pharmacy Permit Number PHY 44527 to Chang Ho Yoo, dba PCH Medical Pharmacy (Respondent PCH Medical Pharmacy). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on January 1, 2020, unless renewed. Chang Ho Yoo (Respondent Yoo) is and has been the Individual Licensed Owner of Respondent PCH Medical Pharmacy since January 13, 2000. Respondent Yoo was the Pharmacist-in-Charge from January 31, 2016 to August 1, 2018. Seung Pil Sun (Respondent Sun) was the Pharmacist-in-Charge from July 1, 2015 to January 31, 2016, and is and has been the Pharmacist-in-Charge since August 1, 2018.

3. On or about August 9, 1988, the Board of Pharmacy issued Pharmacist License Number RPH 42018 to Chang Ho Yoo (Respondent Yoo). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2021, unless renewed.

4. On or about March 19, 2015, the Board of Pharmacy issued Pharmacist License Number RPH 72473 to Seung Pil Sun (Respondent Sun). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2020, unless renewed.

JURISDICTION

5. 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.

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

7. Section 4300 of the Code states, in pertinent part, that "[e]very license issued 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.

9. Section 4302 states:

The board may deny, suspend, or revoke any license of a corporation where conditions exist in relation to any person holding 10 percent or more of the corporate stock of the corporation, or where conditions exist in relation to any officer or director of the corporation that would constitute grounds for disciplinary action against a licensee.

STATUTORY PROVISIONS

10. Section 4059 of the Code states:

(a) A person may not furnish any dangerous drug, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7. A person may not furnish any dangerous device, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7.

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

12. Section 4301 of the Code states:

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

. . .

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

. . .

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

. . .

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

13. Section 4306.5 of the Code states:

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

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

14. Section 4307 states, in pertinent part:

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

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

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

15. Health and Safety Code Section 11153 states, in pertinent part:

(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions:

(1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or

(2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

16. Health and Safety Code section 11162.1 states:

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

. . .

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

. . .

(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.

17. Health and Safety Code section 11164 states, in pertinent part:

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:

REGULATORY PROVISIONS

18. 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.

19. Federal Code of Regulations, title 21, section 1306.05 states, in pertinent part:

(a) All prescriptions for controlled substances shall be dated as of, and signed on, the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use, and the name, address and registration number of the practitioner.

DEFINITIONS

20. Section 4022 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.

21. Section 4036.5 states:

"Pharmacist-in-charge" means a pharmacist proposed by a pharmacy and approved by the board as the supervisor or manager responsible for ensuring the pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy.

22. Oxycodone is 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. Oxycodone is an opioid pain medication.

COST RECOVERY

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

FACTUAL ALLEGATIONS

24. The Controlled Substance Utilization Review and Evaluation System (CURES) is California's Prescription Drug Monitoring Program (PDMP). Pharmacies in California are required to report all filled prescriptions for Schedule II, III, and IV controlled substances to the database every week. The data is collected statewide and can be used by licensed prescribers and pharmacists to evaluate and determine whether their patients are utilizing controlled substances correctly and whether a patient has used multiple prescribers and multiple pharmacies to fill controlled substance prescriptions. Law enforcement and regulatory agencies such as the Board have access to the CURES database for official oversight or investigatory purposes.

25. The Board analyzed CURES dispensing data reported by Respondent PCH Medical Pharmacy and determined that the pharmacy filled a number of prescriptions under the prescribing authority of Dr. Annamalai Ashokan. Previous Board investigations of other pharmacies had identified prescriptions from Dr. Ashokan that did not conform to the written prescription requirements of Health and Safety Code section 11162.1.

///

26. On or about May 14, 2019, the Board conducted an inspection of Respondent PCH Medical Pharmacy. Respondent Sun, Pharmacist-in-Charge, was present during the inspection.

27. The Board inspector collected data of all prescriptions filled by Respondent PCH Medical Pharmacy from May 14, 2016 to May 14, 2019. A review of all the prescriptions from Dr. Ashokan during this time period reflected the following dispensing trends:

MEDICATION	CONTROLLED SUBSTANCE	NUMBER OF PRESCRIPTIONS	PERCENT OF DR. ASHOKAN'S PRESCRIPTIONS FILLED
Oxycodone HCI 30 mg	Yes – Schedule II	219	57.63%
Cyclobenzaprine 10 mg	No	64	16.84%
Doc-q-lace 100 mg	No	63	16.58%
Ibuprofen 800 mg	No	30	7.89%
Gabapentin 800 mg	No	4	1.05%
TOTAL		380	100.00%

28. The Board's investigation identified multiple objective factors of irregularity—or red flags—indicating that Dr. Ashokan's prescriptions for a controlled substance (Oxycodone) were not issued for a legitimate medical purpose. These red flags include, but are not limited to:

(a) ***Oxycodone constituted over 50% of Dr. Ashokan's prescriptions***

29. Of the 380 total prescriptions Respondent PCH Medical Pharmacy received from Dr. Ashokan, 57.63% prescribed oxycodone, a commonly abused medication. Oxycodone not only accounted for over half of Dr. Ashokan's prescribing, but it was also the only controlled substance prescribed by Dr. Ashokan, according to Respondent PCH Medical Pharmacy's prescription records.

(b) ***Oxycodone 30 mg was prescribed to all 48 of Dr. Ashokan's patients***

30. Respondent PCH Medical Pharmacy filled prescriptions from Dr. Ashokan for a total forty-eight (48) patients. All forty-eight (48) patients had at least one prescription from Dr. Ashokan for Oxycodone at the same 30 mg strength, regardless of inter-patient variability in age, weight, drug allergies, medical histories, severity of symptoms being treated, tolerance to drugs, and patient preferences regarding drug therapy plans.

///

(c) ***The highest available strength (30 mg) was prescribed in all 219 Oxycodone prescriptions***

31. Respondent PCH Medical Pharmacy filled 219 prescriptions from Dr. Ashokan for oxycodone. All 219 prescriptions were for an immediate-release formulation of oxycodone. Immediate-release oxycodone is available in 5 mg, 10 mg, 15 mg, 20 mg, and 30 mg strengths. For all 219 oxycodone prescriptions, Dr. Ashokan exclusively prescribed 30 mg, the highest available strength, despite the standard practice of prescribers to treat patients with the lowest effective dose of medication (to minimize risk of side effects and toxicity) and to also initiate therapy with a low dosage of medication and increase only if necessary.

(d) ***Multiple, consecutive Oxycodone prescriptions were processed in a day***

32. On numerous dates, Respondent PCH Medical Pharmacy processed multiple prescriptions from Dr. Ashokan on the same day. Often, these prescriptions were processed within minutes of each other and assigned consecutive or nearly consecutive prescription numbers by the dispensing computer software, indicating that Respondent PCH Medical Pharmacy processed the prescriptions consecutively or nearly consecutively. For example:

33. On May 23, 2016, between 3:17 p.m. and 3:35 p.m., Respondent PCH Medical Pharmacy processed eight (8) prescriptions for four (4) patients from Dr. Ashokan. All four (4) patients received prescriptions for 120 Oxycodone 30 mg tablets.

Date and Time	Rx	Patient	Medication	Quantity
5/23/2016 15:17	7559797	LM	Oxycodone HCl 30 mg tablet	120
5/23/2016 15.:19	7559798	LM	Ibuprofen 800 mg tablet	30
5/23/2016 15:24	7559801	SG	Oxycodone HCl 30 mg tablet	120
5/23/2016 15:27	7559802	SG	Cyclobenzaprine 10 mg tablet	30
5/23/2016 15:32	7559804	DA	Oxycodone HCl 30 mg tablet	120
5/23/2016 15:33	7559805	DA	Cyclobenzaprine 10 mg tablet	30
5/23/2016 15:35	7559806	LP	Oxycodone HCl 30 mg tablet	120
	7559807	LP	Gabapentin 800 mg tablet	

34. On May 31, 2016, between 2:42 p.m. and 3:27 p.m., Respondent PCH Medical Pharmacy processed sixteen (16) prescriptions for eight (8) patients from Dr. Ashokan. All eight (8) patients received prescriptions for 120 oxycodone 30 mg tablets.

Date and Time	Rx	Patient	Medication	Quantity
5/31/2016 14:42	7560099	DS	Oxycodone HCl 30 mg tablet	90
5/31/2016 14:45	7560100	DS	Oxycodone HCl 30 mg tablet	30
	7560101	DS	Ibuprofen 800 mg tablet	30
5/31/2016 14:50	7560102	MC Sr.	Oxycodone HCl 30 mg tablet	120
5/31/2016 14:53	7560103	MC Sr.	Ibuprofen 800 mgtablet	30
5/31/2016 15:02	7560104	MS	Oxycodone HCl 30 mg tablet	90
	7560105	MS	Oxycodone HCl 30 mg tablet	30
5/31/2016 15:03	7560106	MS	Gabapentin 800 mg tablet	30
5/31/2016 15:05	7560107	LW	Oxycodone HCl 30 mg tablet	90
5/31/2016 15:08	7560108	LW	Oxycodone HCl 30 mg tablet	30
	7560109	LW	Ibuprofen 800 mg tablet	30
5/31/2016 15:09	7560110	SSL	Oxycodone HCl 30 mg tablet	120
5/31/2016 15:10	7560111	SSL	Ibuprofen 800 mg tablet	30
5/31/2016 15:16	7560112	KW	Oxycodone HCl 30 mg tablet	120
5/31/2016 15:17	7560113	KW	Ibuprofen 800 mg tablet	30
5/31/2016 15:21	7560114	MW	Oxycodone HCl 30 mg tablet	90
5/31/2016 15:22	7560115	MW	Oxycodone HCl 30 mg tablet	30
5/31/2016 15:23	7560116	MW	Ibuprofen 800 mg tablet	30
5/31/2016 15:26	7560117	JM	Oxycodone HCl 30 mg tablet	90
5/31/2016 15:27	7560118	JM	Oxycodone HCI 30 mg tablet	30
	7560119	JM	Cyclobenzaprine 10 mg tablet	30

35. On August 22, 2016, between 3:11 p.m. and 4:27 p.m., Respondent PCH Medical Pharmacy processed sixteen (16) prescriptions for eight (8) patients from Dr. Ashokan. All eight (8) patients received identical prescriptions for 120 oxycodone 30 mg tablets.

Date and Time	Rx	Patient	Medication .	Quantity
8/22/2016 15:11	7563242	LW	Oxycodone 30 mg tablet	120
8/22/2016 15:12	7563243	LW	Doc-q-lace 100 mg softgel	30
8/22/2016 15:14	7563244	MC	Oxycodone 30 mg tablet	90
	7563245	MC	Oxycodone 30 mg tablet	30
8/22/2016 15:15	7563246	MC	Doc-q-lace 100 mg softgel	30
8/22/2016 15:16	7563247	MW	Oxycodone 30 mg tablet	90
8/22/2016 15:17	7563248	MW	Oxycodone 30 mg tablet	30
8/22/2016 15:18	7563249	MW	Ibuprofen 800 mg tablet	30
	7563250	LP	Oxycodone 30 mg tablet	120
8/22/2016 15:19	7563251	LP	Doc-q-lace 100 mg softgel	30
8/22/2016 15:21	7563254	LM	Oxycodone 30 mg tablet	120

8/22/2016 15:22	7563255	LM	Doc-q-lace 100 mg softgel	30
8/22/2016 15:23	7563257	SG	Oxycodone 30 mg tablet	120
8/22/2016 15:24	7563258	SG	Doc-q-lace 100 mg softgel	30
8/22/2016 15:25	7563260	JM	Oxycodone 30 mg tablet	120
8/22/2016 15:26	7563261	JM	Cyclobenzaprine 10 mg tablet	30
8/22/2016 16:21	7563290	DL	Oxycodone 30 mg tablet	120
8/22/2016 16:27	7563291	DL	Doc-q-lace 100 mg soffgel	30

36. On October 26, 2016, between 12:35 p.m. and 3:55 p.m., Respondent PCH Medical Pharmacy processed twenty-seven (27) prescriptions for fourteen (14) patients from Dr. Ashokan. All fourteen (14) patients received prescriptions for oxycodone 30 mg tablets—thirteen (13) of them received prescriptions for 120 tablets, and one (1) of them received prescriptions for 150 tablets.

Date and Time	Rx	Patient	Medication	Quantity
10/26/2016 12:35	7566086	MW	Oxycodone 30 mg tablet	90
10/26/2016 12:36	7566087	MW	Oxycodone 30 mg tablet	30
10/26/2016 12:37	7566088	MW	Gabapentin 800 mg tablet	30
10/26/2016 14:18	7566099	DL	Oxycodone 30 mg tablet	120
10/26/2016 14:19	7566100	DL	Cyclobenzaprine 10 mg tablet	30
10/26/2016 14:23	7566105	MC	Oxycodohe 30 mg tablet	90
10/26/2016 14:24	7566107	MC	Oxycodone 30 mg tablet	30
10/26/2016 14:25	7566108	MC	Cyclobenzaprine 10 mg tablet	30
10/26/2016 14:28	7566110	MC, Sr.	Oxycodone 30 mg tablet	120
10/26/2016 14:30	7566111	MC, Sr.	Cyclobenzaprine 10 mg tablet	30
10/26/2016 14:33	7566113	SSL	Oxycodone 30 mg tablet	90
10/26/2016 14:34	7566114	SSL	Oxycodone 30 mg tablet	30
10/26/2016 14:35	7566115	SSL	Doc-q-lace 100 mg softgel	30
10/26/2016 14:39	7566116	DW	Oxycodone 30 mg tablet	90
10/26/2016 14:40	7566117	DW	Oxycodone 30 mg tablet	30
10/26/2016 14:41	7566118	DW	Doc-q-lace 100 mg softgel	30
10/26/2016 14:48	7566128	CM	Oxycodone 30 mg tablet	90
10/26/2016 14:49	7566129	CM	Oxycodone 30 mg tablet	30
10/26/2016 15:00	7566136	BP	Oxycodone 30 mg tablet	120
10/26/2016 15:02	7566137	BP	Doc-q-lace 100 mg softgel	30
10/26/2016 15:27	7566146	RH	Oxycodone 30 mg tablet	90
10/26/2016 15:28	7566147	RH	Oxycodone 30 mg tablet	60
10/26/2016 15:29	7566148	RH	Doc-q-lace 100 mg softgel	30
10/26/2016 15:36	7566153	BSJ	Oxycodone 30 mg tablet	120
10/26/2016 15:37	7566154	BSJ	Cyclobenzaprine 10 mg tablet	30

10/26/2016 15:44	7566155	MS	Oxycodone 30 mg tablet	90
10/26/2016 15:45	7566156	MS	Oxycodone 30 mg tablet	30
10/26/2016 15:46	7566157	MS	Doc-q-lace 100 mg softgel	30
10/26/2016 15:48	7566160	KW	Oxycodone 30 mg tablet	90
10/26/2016 15:49	7566161	KW	Oxycodone 30 mg tablet	30
	7566162	KW	Doc-q-lace 100 mg softgel	30
10/26/2016 15:52	7566167	PB	Oxycodone 30 mg tablet	120
	7566168	PB	Cyclobenzaprine 10 mg tablet	30
10/26/2016 15:54	7566169	EE	Oxycodone 30 mg tablet	120
10/26/2016 15:55	7566170	EE	Doc-q-lace 100 mg softgel	30

37. On November 28, 2016, between 1:49 p.m. and 4:22 p.m., Respondent PCH Medical Pharmacy processed twenty-nine (29) prescriptions for fifteen (15) patients from Dr. Ashokan. All fifteen (15) patients received prescriptions for 120 oxycodone 30 mg tablets.

Date and Time	**Rx**	**Patient**	**Medication**	**Quantity**
11/28/2016 13:49	7567503	MW	Oxycodone 30 mg tablet	90
11/28/2016 13:50	7567507	MW	Oxycodone 30 mg tablet	30
11/28/2016 13:51	7567508	MW	Cyclobenzaprine 10 mg tablet	30
11/28/2016 13:55	7567509	DS	Oxycodone 30 mg tablet.	90
11/28/2016 13:56	7567510	DS	Oxycodone 30 mg tablet	30
11/28/2016 13:57	7567511	DS	Doc-q-lace 100 mg softgel	30
11/28/2016 14:03	7567522	EE	Oxycodone 30 mg tablet	120
	7567523	EE	Doc-q-lace 100 mg softgel	30
11/28/2016 14:06	7567528	BSJ	Oxycodone 30 mg tablet	120
11/28/2016 14:07	7567529	BSJ	Ibuprofen 800 mg tablet	30
11/28/2016 14:09	7567533	MC	Oxycodone 30 mg tablet	90
11/28/2016 14:10	7567534	MC	Oxycodone 30 mg tablet	30
11/28/2016 14:11	7567535	MC	Cyclobenzaprine 10 mg tablet	30
11/28/2016 14:18	7567542	MS	Oxycodone 30 mg tablet	90
11/28/2016 14:19	7567543	MS	Oxycodone 30 mg tablet	30
	7567544	MS	Cyclobenzaprine 10 mg tablet	30
11/28/2016 15:03	7567554	BP	Oxycodone 30 mg tablet	120
11/28/2016 15:19	7567564	CM	Oxycodone 30 mg tablet	90
11/28/2016 15:32	7567565	CM	Oxycodone 30 mg tablet	30
11/28/2016 15:35	7567566	CM	Cyclobenzaprine 10 mg tablet	30
11/28/2016 15:37	7567569	KW	Oxycodone 30 mg tablet	90
11/28/2016 15:38	7567570	KW	Oxycodone 30 mg tablet	30
11/28/2016 15:39	7567571	KW	Doc-q-lace 100 mg softgel	30
11/28/2016 15:43	7567572	SSL	Oxycodone 30 mg tablet	90
11/28/2016 15:44	7567573	SSL	Oxycodone 30 mg tablet	30

11/28/2016 15:45	7567574	SSL	Cyclobenzaprine 10 mg tablet	30
11/28/2016 15:48	7567579	PB	Oxycodone 30 mg tablet	90
11/28/2016 15:49	7567580	PB	Oxycodone 30 mg tablet	30
	7567581	PB	Cyclobenzaprine 10 mg tablet	30
11/28/2016 15:53	7567582	MC,Sr.	Oxycodone 30 mg tablet	120
11/28/2016 15:54	7567583	MC,Sr.	Doc-q-lace 100 mg softgel	30
11/28/2016 15:59	7567591	DC	Oxycodone 30 mg tablet	90
11/28/2016 16:00	7567592	DC	Oxycodone 30 mg tablet	30
	7567593	DC	Doc-q-:lace 100 mg softgel	30
11/28/2016 16:11	7567598	JT	Oxycodone 30 mg tablet	90
	7567599	JT	Oxycodone 30 mg tablet	30
11/28/2016 16:12	7567600	JT	Cyclobenzaprine 10 mg tablet	30
'11/28/2016 16:19	7567603	TA	Oxycodone 30 mg tablet	90
11/28/2016 16:21	7567604	TA	Oxycodone 30 mg tablet	30
11/28/2016 16:22	7567605	TA	Ibuprofen 800 mg tablet	30

(e) ***Patients had addresses of record excessively far from PCH Medical Pharmacy***

38. Of the forty-eight (48) patients who had Dr. Ashokan's prescriptions filled by Respondent PCH Medical Pharmacy, twenty-three (23) of them had addresses of record that were more than twenty (20) miles from Respondent PCH Medical Pharmacy, which is located in Long Beach, California. Together, these twenty-three (23) patients received 193 prescriptions from Dr. Ashokan that were ultimately filled by Respondent PCH Medical Pharmacy.

(f) ***Dr. Ashokan's written prescriptions lacked required security features***

39. The Board's investigator reviewed sixty (60) prescription documents for Oxycodone 30 mg from Dr. Ashokan that had been filled by Respondent PCH Medical Pharmacy. These prescription documents failed to include a lot number and a "California Security Prescription" watermark—both security features that are required by law. These omitted security features alone invalidated the prescriptions and visibly indicated that the prescriptions were not written legitimately.

(g) ***Dr. Ashokan's written prescriptions had incorrect issue dates***

40. Seven (7) of the reviewed prescription documents were dated September 27, 2016 but were processed and dispensed by Respondent PCH Medical Pharmacy on September 26, 2016. These prescriptions were also invalid because they had patently incorrect issue dates.

41. None of the sixty (60) prescription documents had handwritten notes indicating a pharmacist at Respondent PCH Medical Pharmacy had ever contacted Dr. Ashokan to obtain additional information to validate the prescriptions.

42. Given these numerous factors of irregularity, all Respondents knew, or had objective reason to know, that there were potential problems with Dr. Ashokan's prescriptions. These red flags put all Respondents on notice to conduct further inquiries into the legitimacy of the prescriptions.

43. The Board inspector reviewed additional CURES data for three other pharmacies located near both Respondent PCH Medical Pharmacy and Dr. Ashokan's office and therefore similarly accessible to Dr. Ashokan's patients. The data showed that from May 16, 2016 to May 14, 2019, none of these three pharmacies filled any prescriptions from Dr. Ashokan. This trend suggests that Dr. Ashokan's patients from this time period had specifically identified PCH Medical Pharmacy as a location where Dr. Ashokan's prescriptions could be filled.

FIRST CAUSE FOR DISCIPLINE

(Failure to Exercise or Implement Corresponding Responsibility)

44. Respondent PCH Medical Pharmacy, Respondent Sun, and Respondent Yoo are subject to disciplinary action under sections 4301, subdivisions (d), (j), and (o); 4306.5, subdivision (b); 4302; and 4113, subdivision (c); in conjunction with Health and Safety Code section 11153, subdivision (a); and California Code of Regulations, title 16, section 1761; in that Respondents failed to exercise or implement their best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances or dangerous drugs, or with regard to the provision of services. Complainant refers to, and by this reference incorporates, the allegations set forth in above paragraphs 24 through 43, as though set forth in full herein.

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SECOND CAUSE FOR DISCIPLINE

(Filling or Dispensing Improper Prescriptions for Controlled Substances)

45. Respondent PCH Medical Pharmacy, Respondent Sun, and Respondent Yoo are subject to disciplinary action under sections 4301, subdivisions (d), (j), and (o); 4306.5, subdivision (b); 4302; and 4113, subdivision (c); in conjunction with Health and Safety Code sections 11164 and 11162.1, subdivisions (a) and (b); California Code of Regulations, title 16, section 1761; and Federal Code of Regulations, title 21, section 1306.05; in that Respondents filled or dispensed controlled substance prescriptions that did not comply with the form requirements of Health and Safety Code section 11162.1, or contained any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Complainant refers to, and by this reference incorporates, the allegations set forth in above paragraphs 24 through 43, as though set forth in full herein.

OTHER MATTERS

46. Pursuant to section 4307 of the Code, if discipline is imposed on Pharmacy Permit Number PHY 44527 issued to Respondent Chang Ho Yoo, dba PCH Medical Pharmacy, Respondent PCH Medical Pharmacy 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 44527 is placed on probation or until Pharmacy Permit Number PHY 44527 is reinstated if it is revoked.

47. Pursuant to section 4307 of the Code, if discipline is imposed on Pharmacy Permit Number PHY 44527 issued to Respondent Chang Ho Yoo, dba PCH Medical Pharmacy while Respondent Seung Pil Sun has been an officer and owner and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Respondent Seung Pil Sun 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 44527 is placed on probation or until Pharmacy Permit Number PHY 44527 is reinstated if it is revoked.

48. Pursuant to section 4307 of the Code, if discipline is imposed on Pharmacy Permit Number PHY 44527 issued to Respondent Chang Ho Yoo, dba PCH Medical Pharmacy while

Respondent Chang Ho Yoo has been an officer and owner and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Respondent Chang Ho Yoo 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 44527 is placed on probation or until Pharmacy Permit Number PHY 44527 is reinstated if it is revoked.

DISCIPLINE CONSIDERATIONS

49. To determine the degree of discipline, if any, to be imposed on Respondent PCH Medical Pharmacy, Respondent Chang Ho Yoo, and Respondent Seung Pil Sun, Complainant alleges that on or about February 19, 2019, in a prior action titled *In the Matter of the Citation Against Chang-Ho Yoo*, the Board issued Citation Number CI 2018 80744 to Respondent Yoo for a violation of Code section 4077, subdivision (a) [dispensing dangerous drug in incorrectly labeled container]. A copy of the Modified Citation and Fine and Order of Abatement is attached as Exhibit A.

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 44527, issued to Chang Ho Yoo, dba PCH Medical Pharmacy;

2. Revoking or suspending Pharmacist License Number RPH 42018, issued to Chang Ho Yoo;

3. Revoking or suspending Pharmacist License Number RPH 72473, issued to Seung Pil Sun;

4. Prohibiting Chang Ho Yoo, dba PCH Medical Pharmacy from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 44527 is placed on probation or until Pharmacy Permit Number PHY 44527 is reinstated if Pharmacy Permit Number PHY 44527 issued to Chang Ho Yoo, dba PCH Medical Pharmacy is revoked;

5. Prohibiting Chang Ho Yoo from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 44527 is placed on probation or until Pharmacy Permit Number PHY 44527 is reinstated if Pharmacy Permit Number PHY 44527 issued to Chang Ho Yoo, dba PCH Medical Pharmacy is revoked;

6. Prohibiting Seung Pil Sun from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 44527 is placed on probation or until Pharmacy Permit Number PHY 44527 is reinstated if Pharmacy Permit Number PHY 44527 issued to Chang Ho Yoo, dba PCH Medical Pharmacy is revoked;

7. Ordering Chang Ho Yoo, dba PCH Medical Pharmacy, Chang Ho Yoo, and Seung Pil Sun 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,

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

DATED: December 2, 2019

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

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