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

In the Matter of the Accusation Against:

NCRXONE, INC., dba
NEW CENTURY PHARMACY,
JASON MYUNGJOON KIM,
Pharmacy Permit No. PHY 45171;

and

JASON MYUNGJOON KIM,
Pharmacist License No. RPH 39008,

Respondents.

Agency Case No. 6878

OAH No. 2021070820

DECISION AND ORDER

The attached Stipulated Surrender of License 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 March 30, 2022.

It is so ORDERED on February 28, 2022.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

Seung W. Oh, Pharm.D.
Board President

ROB BONTA
Attorney General of California
NANCY KAISER
Supervising Deputy Attorney General
MELISSA TYNER
Deputy Attorney General
State Bar No. 269649
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6314
Facsimile: (916) 731-2126
E-mail: Melissa.Tyner@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against**:** **NCRXONE, INC. DBA NEW CENTURY PHARMACY, JASON MYUNGJOON KIM** **8227 Woodman** **Panorma City, CA 91402** **Permit No. PHY 45171,** **and** **JASON MYUNGJOON KIM** **8227 Woodman Ave** **Panorama City, CA 91402** **Pharmacist License No. RPH 39008** Respondents.	Case No. 6878 OAH No. 2021070820 **STIPULATED SURRENDER OF LICENSE AND ORDER OF NCRXONE, INC. DBA NEW CENTURY PHARMACY ONLY**

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 Rob Bonta, Attorney General of the State of California, by Melissa Tyner, Deputy Attorney General.

2. Ncrxone, Inc. dba New Century Pharmacy, Jason Myungjoon Kim (Respondent) is representing itself in this proceeding and has chosen not to exercise its right to be represented by counsel.

3. On or about February 1, 2001, the Board issued Permit No. PHY 45171 to Ncrxone, Inc. dba New Century Pharmacy, Jason Myungjoon Kim (Respondent). The Permit was in full force and effect at all times relevant to the charges brought in Accusation No. 6878 and will expire on February 1, 2020, unless renewed.

JURISDICTION

4. Accusation No. 6878 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 28, 2020. Respondent timely filed its Notice of Defense contesting the Accusation. A copy of Accusation No. 6878 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Accusation No. 6878. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of its legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at its own expense; the right to confront and cross-examine the witnesses against them; the right to present evidence and to testify on its 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.

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

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 6878, agrees that cause exists for discipline and hereby surrenders their Permit No. PHY 45171 for the Board's formal acceptance.

9. Respondent understands that by signing this stipulation it enables the Board to issue an order accepting the surrender of its Permit without further process.

CONTINGENCY

10. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent. By signing the stipulation, Respondent understands and agrees that they may not withdraw its 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 Surrender 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.

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

12. This Stipulated Surrender of License and 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 Surrender of License and 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.

13. 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 Order:

ORDER

IT IS HEREBY ORDERED that Permit No. PHY 45171, issued to Respondent Ncrxone, Inc. dba New Century Pharmacy, Jason Myungjoon Kim, is surrendered and accepted by the Board.

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

2. Respondent 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 shall cause to be delivered to the Board its pocket license and, if one was issued, its wall certificate on or before the effective date of the Decision and Order.

4. If it 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 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. 6878 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the application or petition. Respondent is required to report this surrender as disciplinary action. Respondent may not apply for any license, permit, or registration from the Board for three years from the effective date of this decision.

5. Respondent shall pay $30,425.00 in costs prior to issuance of a new or reinstated license. Respondent and Jason Myungjoon Kim shall be jointly and severally liable for payment of these costs.

6. If Respondent 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. 6878 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Permit. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: _____

_____
NCRXONE, INC. DBA NEW CENTURY PHARMACY, JASON MYUNGJOON KIM
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Pharmacy of the Department of Consumer Affairs.

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
NANCY KASIER
Supervising Deputy Attorney General

MELISSA TYNER
Deputy Attorney General
Attorneys for Complainant

LA2020500767
64798478.docx

ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Permit. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 1/11/2022

NCRXONE, INC. DBA NEW CENTURY PHARMACY, JASON MYUNGJOON KIM
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Pharmacy of the Department of Consumer Affairs.

DATED: 1/12/22

Respectfully submitted,

ROB BONTA
Attorney General of California
NANCY KASIER
Supervising Deputy Attorney General

MELISSA TYNER
Deputy Attorney General
Attorneys for Complainant

LA2020500767
64798478.docx

Exhibit A

Accusation No. 6878

XAVIER BECERRA
Attorney General of California
MARC D. GREENBAUM
Supervising Deputy Attorney General
MORGAN MALEK
Deputy Attorney General
State Bar No. 223382
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6278
Facsimile: (916) 731-2126
Attorneys for Complainant

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

In the Matter of the Accusation Against**:** **NCRXONE, INC. DBA NEW CENTURY PHARMACY, JASON MYUNGJOON KIM** **8227 Woodman** **Panorama City, CA 91402** **Permit No. PHY 45171,** **and** **JASON MYUNGJOON KIM** **8227 Woodman Ave** **Panorama City, CA 91402** **Pharmacist License No. RPH 39008** Respondents.	Case No. 6878 **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.

2. On or about February 1, 2001, the Board of Pharmacy issued Permit Number PHY 45171 to Ncrxone, Inc. dba New Century Pharmacy, Jason Myungjoon Kim (Respondent

Pharmacy). The Permit was in full force and effect at all times relevant to the charges brought herein and will expire on February 1, 2022, unless renewed.

3. On or about September 19, 1984, the Board of Pharmacy issued Pharmacist License Number RPH 39008 to Jason Myungjoon Kim (Respondent PIC). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2022, unless renewed.

JURISDICTION

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

5. **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."

6. **Section 4300** of the Code states, in pertinent part:

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

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

"(1) Suspending judgment.

"(2) Placing him or her upon probation.

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

"(4) Revoking his or her license.

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

. . . .

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

STATUTES AND REGULATIONS

7. **Section 4013**, subdivision (a) of the Code states:

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

8. **Section 4059**, subdivision (a), of the Code states:

"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."

9. **Section 4301,** subdivision (f), 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:

. . . .

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

10. **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.

11. **Section 11153,** subdivision (a), of the **Health & Safety Code** states, in pertinent part:

"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."

12. **Section 11165,** subdivision (d), of the **Health & Safety Code** states, in pertinent part: "For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, and respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed, in a format specified by the Department of Justice:

(1) Full name, address, and, if available, telephone number 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, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility, if provided.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(11) The serial number for the corresponding prescription form, if applicable."

13. **Section 11167** of the Health & Safety Code states, in pertinent part:

"Notwithstanding subdivision (a) of Section 11164, in an emergency where failure to issue a prescription may result in loss of life or intense suffering, an order for a controlled substance may be dispensed on an oral order, an electronic data transmission order, or a written order not made on a controlled substance form as specified in Section 11162.1, subject to all of the following requirements:

(a) The order contains all information required by subdivision (a) of Section 11164.

(b) Any written order is signed and dated by the prescriber in ink, and the pharmacy reduces any oral or electronic data transmission order to hard copy form prior to dispensing the controlled substance.

(c) The prescriber provides a written prescription on a controlled substance prescription form that meets the requirements of Section 11162.1, by the seventh day following the transmission of the initial order; a postmark by the seventh day following transmission of the initial order shall constitute compliance.

(d) If the prescriber fails to comply with subdivision (c), the pharmacy shall so notify the Department of Justice in writing within 144 hours of the prescriber's failure to do so and shall make and retain a hard copy, readily retrievable record of the prescription, including the date and method of notification of the Department of Justice.

(e) This section shall become operative on January 1, 2005."

14. **Section 111440** of the **Health & Safety Code** states, in pertinent part:

"It is unlawful for any person to manufacture, sell, deliver, hold, or offer for sale any drug or device that is misbranded."

15. **California Code of Regulations, title 16, section 1707.5,** subdivision (a), states:

"Labels on drug containers dispensed to patients in California shall conform to the following format:

(1) Each of the following items, and only these four items, shall be clustered into one area of the label that comprises at least 50 percent of the label. Each item shall be printed in at least a 12-point sans serif typeface, and listed in the following order:

(A) Name of the patient

(B) Name of the drug and strength of the drug. For the purposes of this section, "name of the drug" means either the manufacturer's trade name of the drug, or the generic name and the statement "generic for _____" where the brand name is inserted and the name of the manufacturer. In the professional judgment of the pharmacist:

(i) If the brand name is no longer widely used, the label may list only the generic name of the drug, and

(ii) The manufacturer's name may be listed outside of the patient-centered area.

(C) The directions for the use of the drug.

(D) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(2) For added emphasis, the label shall also highlight in bold typeface or color, or use blank space to set off the items listed in subdivision (a)(1).

(3) The remaining required elements for the label specified in section 4076 of the Business and Professions Code, as well as any other items of information appearing on the label or the container, shall be printed so as not to interfere with the legibility or emphasis of the primary elements specified in paragraph (1) of subdivision (a). These additional elements may appear in any style, font, and size typeface.

(4) When applicable, directions for use shall use one of the following phrases:

(A) Take 1 [insert appropriate dosage form] at bedtime

(B) Take 2 [insert appropriate dosage form] at bedtime

(C) Take 3 [insert appropriate dosage form] at bedtime

(D) Take 1 [insert appropriate dosage form] in the morning

(E) Take 2 [insert appropriate dosage form] in the morning

(F) Take 3 [insert appropriate dosage form] in the morning

(G) Take 1 [insert appropriate dosage form] in the morning, and Take 1 [insert appropriate dosage form] at bedtime

(H) Take 2 [insert appropriate dosage form] in the morning, and Take 2 [insert appropriate dosage form] at bedtime

(I) Take 3 [insert appropriate dosage form] in the morning, and Take 3 [insert appropriate dosage form] at bedtime

(J) Take 1 [insert appropriate dosage form] in the morning, 1 [insert appropriate dosage form] at noon, and l [insert appropriate dosage form] in the evening

(K) Take 2 [insert appropriate dosage form] in the morning, 2 [insert appropriate dosage form] at noon, and 2 [insert appropriate dosage form] in the evening

(L) Take 3 [insert appropriate dosage form] in the morning, 3 [insert appropriate dosage form] at noon, and 3 [insert appropriate dosage form] in the evening

(M) Take 1 [insert appropriate dosage form] in the morning, 1 [insert appropriate dosage form] at noon, 1 [insert appropriate dosage form] in the evening, and 1 [insert appropriate dosage form] at bedtime

(N) Take 2 [insert appropriate dosage form] in the morning, 2 [insert appropriate dosage form] at noon, 2 [insert appropriate dosage form] in the evening, and 2 [insert appropriate dosage form] at bedtime

(O) Take 3 [insert appropriate dosage form] in the morning, 3 [insert appropriate dosage form] at noon, 3 [insert appropriate dosage form] in the evening, and 3 [insert appropriate dosage form] at bedtime

(P) If you have pain, take __ [insert appropriate dosage form] at a time. Wait at least __ hours before taking again. Do not take more than __ [appropriate dosage form] in one day

16. **California Code of Regulations, title 16, section 1714,** subdivision (b), states:

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

17. **California Code of Regulations, title 16, section 1776,** states:

"Pharmacies, hospitals/clinics with onsite pharmacies, distributors and reverse distributors licensed by the board may offer, under the requirements in this article, specified prescription drug take-back services through collection receptacles and/or mail back envelopes or packages to provide options for the public to discard unwanted, unused or outdated prescription drugs. Each entity must comply with regulations of the federal Drug Enforcement Administration (DEA) and this article. Only California-licensed pharmacies, hospitals/clinics with onsite pharmacies, and drug distributors (licensed wholesalers and third-party logistics providers) who are registered with the DEA as collectors and licensed in good standing with the board may host a pharmaceutical take-back receptacle as authorized under this article."

18. **Code of Federal Regulations, section 1304.04, subdivision (h),** states:

"Each registered pharmacy shall maintain the inventories and records of controlled substances as follows:

(1) Inventories and records of all controlled substances listed in Schedule I and II shall be maintained separately from all other records of the pharmacy.

(2) Paper prescriptions for Schedule II controlled substances shall be maintained at the registered location in a separate prescription file.

(3) Inventories and records of Schedules III, IV, and V controlled substances shall be maintained either separately from all other records of the pharmacy or in such form that the information required is readily retrievable from ordinary business records of the pharmacy.

(4) Paper prescriptions for Schedules III, IV, and V controlled substances shall be maintained at the registered location either in a separate prescription file for Schedules III, IV, and V controlled substances only or in such form that they are readily retrievable from the other prescription records of the pharmacy. Prescriptions will be deemed readily retrievable if, at the

time they are initially filed, the face of the prescription is stamped in red ink in the lower right corner with the letter "C" no less than 1 inch high and filed either in the prescription file for controlled substances listed in Schedules I and II or in the usual consecutively numbered prescription file for non-controlled substances. However, if a pharmacy employs a computer application for prescriptions that permits identification by prescription number and retrieval of original documents by prescriber name, patient's name, drug dispensed, and date filled, then the requirement to mark the hard copy prescription with a red "C" is waived.

(5) Records of electronic prescriptions for controlled substances shall be maintained in an application that meets the requirements of part 1311 of this chapter. The computers on which the records are maintained may be located at another location, but the records must be readily retrievable at the registered location if requested by the Administration or other law enforcement agent. The electronic application must be capable of printing out or transferring the records in a format that is readily understandable to an Administration or other law enforcement agent at the registered location. Electronic copies of prescription records must be sortable by prescriber name, patient name, drug dispensed, and date filled."

19. **Code of Federal Regulations, section 1305.13, subdivision (e),** states:

"The purchaser must record on its copy of the DEA Form 222 the number of commercial or bulk containers furnished on each item and the dates on which the containers are received by the purchaser."

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

20. **Hydrocodone/acetaminophen ("hydrocodone/apap"), the generic name for Norco and Lortab**, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4) and is a dangerous drug pursuant to Code section 4022. As of October 6, 2014, hydrocodone/apap became a Schedule II controlled substance pursuant to United States Code, title 21, section 812.

21. **Oxycodone, the generic name for Roxicodone**, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M) and is a dangerous drug pursuant to Code section 4022.

22. **Promethazine with Codeine syrup, the generic name for Phenergan with Codeine Syrup,** is a Schedule V controlled substance pursuant to Health and Safety Code section 11058, subdivision (c)(1) and is a dangerous drug pursuant to Code section 4022.

23. **Alprazolam, the generic name for Xanax,** is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1) and is a dangerous drug pursuant to Code section 4022.

COST RECOVERY

24. 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, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

BOARD'S INSPECTION OF JULY 24, 2019

25. On July 24, 2019, Inspector E.D. and Inspector A.B. traveled to Respondent pharmacy to conduct an inspection, along with DEA agents conducting their own investigation. The inspectors interviewed Respondent PIC about the pharmacy's general operations. Respondent PIC stated the following regarding Respondent Pharmacy (Pharmacy):

• The Pharmacy processed approximately 50 prescriptions per day and of that only three to four prescriptions were for Controlled Substance Schedule II.

• The Pharmacy did not compound medications. ·

• Respondent PIC was the only staff of the Pharmacy.

• The Pharmacy wholesalers were: McKesson, ANDA Incorporated (ANDA) and H.D. Smith.

• The pharmacy's reverse distributor was Pharma Link Inc. per Respondent PIC Kim, as of July 24, 2019, the Pharmacy did not use their reverse distributor.

• The Pharmacy's Software was RX30.

Inspector E.D. notified Respondent PIC that she was there to conduct an inspection and requested to look through Pharmacy's shelves, drawers, refrigerator and waiting bin[1].

26. During the inspection, Inspector E.D. requested and received from Respondent the Pharmacy's Drug Utilization Report (DUR)[2] for the period between July 1, 2017 and July 24, 2019. Per Respondent PIC, the provided DUR was an accurate representation of the Pharmacy's dispensing history and hard copy (paper) prescription records. Inspector E.D. requested Respondent PIC to send her the DUR in Excel format.

27. During the inspection, Inspector E.D. noted several pharmacy violations. The pharmacy was disorganized and dirty. Respondent PIC could not locate pharmacy's Self-Assessment, DEA Biennial Inventory and policy and procedures. The posted Pharmacy's permit was expired. The Pharmacy had adulterated, misbranded and expired medications on the active shelves. It had several prescriptions billed to the patients' insurance without being dispensed. There were invoices for controlled substance were not separated.

28. Inspector E.D. located several prescriptions in the waiting bin for which the label did not state the manufacturer's trade name of the drug, or the generic name and the statement "generic for" to be at least 50 percent of the label, at least a 12-point sans serif typeface.

29. While reviewing the waiting bin, Inspector E.D. located several prescriptions in the waiting bin some of which dated back to 2017 and which were billed to the patient's insurance and were not reversed. She asked Respondent PIC why the prescriptions were still billed to the insurance and PIC Kim responded that he "got lazy."

30. Using the provided DUR, Inspector E.D. was able to confirm the below prescriptions were processed through the insurance.

///

///

///

[1] Waiting bin is a location for the prescriptions which were processed and verified by the pharmacist, and which were ready to be dispensed to patients.

[2] DUR is a computer generated report of the pharmacy's dispensing records. It contains the following data elements: date prescription was dispensed, prescription number, drug name, drug strength, quantity dispensed and national drug code (NDC) and some additional information.

RX NUMBER	Medication Number	Fill Date	Insurance
188483	One touch Ultra Test Strips	3/30/2018	Commercial Plan
195271	Prednisone 10 mg tablet	5/23/2019	Commercial Plan
188273	Ferrous Sulfate 325 mg tablet	2/27/2019	Commercial Plan
182054	Amlodipine Besylate 5 mg tablet	10/5/2017	Commercial Plan
194531	Amlodipine Besylate 10 mg tablet	4/5/2019	Medicare Part-D/State
183758	Meclizine 25 mg tablet	8/22/2017	Cash
195151	Simvastatin 20 mg tablet	5/15/2019	Commercial Plan
194926	Glimepiride 4 mg tab	5/31/2019	Commercial Plan
193946	Vit D2 1.25 mg (50,000 unit)	2/28/2019	cash
194109	Albuterol Sulfate HFA 108	3/11/2019	Commercial Plan
175615	Modafinil 100 mg tab	6/30/2016 (not in the dispensing report-DUR)	N/A

31. While reviewing the Pharmacy stock, multiple expired medications, unlabeled prescription vials and return to stock medications, were found in the pharmacy's active stock area. Respondent PIC Kim stated the following:

• Regarding the unlabeled vials near the Pharmacy's filling counter containing Schedule II Controlled Substances: The tablets which were inside the pharmacy's dispensing robot (Parata Min4) were placed in these vials to be sent for destruction. He was planning to send them for destruction (Note: these were not quarantined).

• Regarding the expired medications on the pharmacy's active shelves, Respondent PIC claimed he did not dispense the expired medications and checked the expiration prior to dispensing. He did not quarantine the expired medications because he was concerned that they would get lost. He had last sent his expired medications to his reverse distributor on or about 2016, however, he could not locate the invoice.

32. On the pharmacy floor, Inspector E.D. located several bags which contained several prescriptions which were brought back to the pharmacy. The bag contained the following: ·

• Prescriptions dispensed from Walgreens, CVS and Econo Pharmacy.

• Two prescriptions for Controlled Substance Scheduled II (hydrocodone/ ibuprofen 7 .5-200mg and hydrocodone/ acetaminophen (APAP) 10-325mg).

• Respondent PIC stated he had accepted the unwanted prescription drugs back from patients to discard. Inspector E.D. later confirmed Respondent Pharmacy was not registered with the DEA.

33. During the inspection, the inspectors requested to review the Pharmacy's prescription documents for Schedules II, III, IV, and V controlled substances, Respondent PIC provided two stacks of prescription documents. He explained that prescription documents for Schedule II controlled substances filled on or about 2017 were not maintained at the pharmacy and were stored at his residence. Further, he did not have a waiver for off-site storage. Per Respondent PIC, in 2018, he had started to separate Controlled Substance Scheduled II prescription hardcopies from all other records. Further, inventories and records of Schedules III, IV, and V controlled substances were not maintained separately from other records of the pharmacy and

were comingled with other prescription records. Additionally, during the inspection, Respondent PIC could not locate Pharmacy's DEA Biennial Inventory, and stated it was at his residence.

34. On or about October 3, 2019, photographs were taken of the DEA Form 222 for which the received date was not recorded. Inspector E.D. requested and received from McKesson invoice records related to the DEA 222 forms which lacked the received date.

Date Ordered	Invoice Number
3/26/2018	Unable to locate
2/22/2018	7858134850
3/7/2018	7860198258
3/12/2018	7860922442
2/28/2018	7859024499
2/12/2018	7856247531
2/12/2018	7856247533
2/2/2018	7854820336
1/24/2018	7853043220
1/11/2018	7850859663
1/4/2018	7849566363
12/28/2017	7848467760
12/20/2017	7847128092
12/6/2017	7844606188
11/28/2017	7843069138
11/21/2017	7842030040
11/10/2017	7840041012
11/2/2017	7838825689
10/31/2017	Unable to locate
10/26/2017	Unable to locate

35. During the inspection, the inspectors inquired whether Respondent PIC received emails from the Board regarding drug recalls and other notices. He indicated that he was not registered for the Board's email notifications and was not aware of such requirement.

36. Respondent PIC provided the inspectors with two stacks of Controlled Substance Schedule II prescription documents and stated they represented the prescriptions dispensed at Respondent Pharmacy between 2018 and the date of the inspection (July 24, 2019).

37. On July 24, 2019, the DEA collected the majority of the records related to controlled substance as evidence. The prescription records dispensed under the following prescribers did not conform to the requirements of Health and Safety Code Section 11164 and 11162.1:

- Photographs of 304 controlled substance prescriptions written on prescription documents prescription under Dr. R. Goldstein (Dr. RG) lacked the following security features: (1) A watermark printed on the backside of the prescription document consisting of the words "California Security Prescription"; (2) The watermark printed on the back stated "DocuGard"; (3) An identifying number assigned to the approved security printer by the Department of Justice; and (4) Refill Check boxes so that the prescriber may indicate the number of refills ordered. Further, besides the lack of security features of the prescription document, the majority of prescriptions: (1) Did not have complete directions. The prescriptions were written for "po bid", which meant "by mouth twice a day" or "po bid q12", which meant "by mouth twice every 12". These were incomplete directions since it was not clear how many pills twice or every 12; (2) The prescriptions were dispensed for the following medications: oxycodone 30 mg, hydrocodone/ acetaminophen 10-325 mg, promethazine/codeine and Adderall.
- Photographs of 10 controlled substance prescriptions written on prescription documents prescription under Dr. D. Smith (Dr. DS) lacked the following security features: (1) A watermark printed on the backside of the prescription document consisting of the words "California Security Prescription"; (2) The watermark printed on the back stated "DocuGard"; (3) The lot number printed on the

prescription document for each batch of controlled substance prescription forms; and (3) An identifying number assigned to the approved security printer by the Department of Justice.

- Photographs of 29 prescription documents under Dr. L. Robb (Dr. LR), lacked the following security features: (1) A watermark printed on the backside of the prescription document consisting of the words "California Security Prescription"; (2) There was no watermark printed on the back; (3) The lot number printed on the prescription document for each batch of controlled substance prescription forms; and (3) Refill Check boxes so that the prescriber may indicate the number of refills ordered. In addition to the lack of security features of the prescription document, the majority of prescriptions: (1) Did not have complete directions. The prescriptions were written for "qd", which means "daily'-' or "po bid", which mean "by mouth twice a day". These were incomplete directions since it was not clear how many pills once or twice a day: (2) The prescriptions were dispensed for the following medications: oxycodone 30mg, hydrocodone/acetaminophen 10-325 mg, promethazine/codeine, Adderall, diazepam and alprazolam.
- Photographs of 19 prescription documents under Dr. J. Wang (Dr. JW). It appeared that the prescriptions had the required security features, however, as described below, they were dispensed without fulfilling corresponding responsibility obligations. In addition, as discussed later in the report, a majority of the prescription dispensed under the prescribing authority of Dr. RG, Dr. DS, Dr. LR and Dr. JW were not reported to CURES.

38. Tables below illustrates photographs of other prescriptions which were not compliant with Health and Safety Code Section 11164 and 11162.l.(the chart below does not include Dr. R.G., D.S., Dr. L.R., and Dr. J.W.)

///

///

///

RX NUMBER	MEDICATION	QTY	DATE FILLED	IRREGULARITIES
196004	Hydrocodone-APAP 10-325	20	7/15/19	-CURES report showed no results -The prescription documents lacked "California Security Prescription" watermark, an identifying number assigned to the approved security printer, the statement "Prescription is void if the number of drugs prescribed is not noted," and "six quantity check off boxes" for the quantity prescribed. Prescriber: Y. Mehrabi
195826	Hydrocodone-APAP 10-325	20	7/1/19	-CURES report showed no results -The prescription documents lacked "California Security Prescription" watermark, an identifying number assigned to the approved security printer, the statement "Prescription is void if the number of drugs prescribed is not noted," and "six quantity check off boxes" for the quantity prescribed. Prescriber: Y. Mehrabi
193480	Hydrocodone-APAP 10-325	20	2/4/19	-CURES report showed no results -The prescription documents lacked "California Security Prescription" watermark, an identifying number assigned to the approved security printer, the statement "Prescription is void if the number of drugs prescribed is not noted," and "six quantity check off boxes" for the quantity prescribed. Prescriber: Y. Mehrabi

RX NUMBER	MEDICATION	QTY	DATE FILLED	IRREGULARITIES
186574	Hydrocodone-APAP 7.5-325	24	1/5/18	Next to the statement "Prescription is void if the number of drugs prescribed is not noted", was left blank. The strength of the medication was altered.

RX NUMBER	MEDICATION	QTY	DATE FILLED	IRREGULARITIES
195997	Hydrocodone w/APAP 5/325 tab	16	7/12/19	CURES report showed no results-The date of the original prescription was not recorded-next to the statement "Prescription is void if the number of drugs prescribed is not noted", was left blank- "six quantity check off boxes" for the quantity prescribed was left blank.

RX NUMBER	MEDICATION	QTY	DATE FILLED	IRREGULARITIES
192817	Diazepam 5 mg tab	30	12/24/18	CURES report showed no results-Prescription was altered with white-out.

RX NUMBER	MEDICATION	QTY	DATE FILLED	IRREGULARITIES
195553	Hydrocodone-APAP 10-325	30	6/14/19	CURES report showed no results-Next to the statement "Prescription is void if the number of drugs prescribed is not noted," was left blank-
195186	Hydrocodone-APAP 10-325	30	5/17/19	CURES report showed no results-Next to the statement "Prescription is void if the number of drugs prescribed is not noted," was left blank-
194799	Hydrocodone-APAP 10-325	30	4/24/19	CURES report showed no results-Next to the statement "Prescription is void if the number of drugs prescribed is not noted," was left blank-
192564	Hydrocodone-APAP 10-325	60	12/7/18	Prescription number 192564 the applicable box for the quantity prescribed in the section of "six quantity check off boxes" was not noted.

39. The inspectors took photographs of several prescriptions. Two of the prescription documents were attached to a copy of the patient's California Driver License. None of the prescriptions contained documentation indicating Respondent PIC contacted the prescribers to discuss the irregularities described above. Additionally, during the inspection on July 24, 2019, Inspector E.D. asked Respondent PIC to provide any and all documentation of attempts to verify

the prescriptions photographed during the inspection, other than what may have been written on the prescription document. Respondent PIC explained he had no additional documentation to provide.

40. The below table summarizes controlled substance prescriptions written on prescription documents which did not comply with Health and Safety Code Section 11164 and 11162.l.

Prescriber	Number of controlled substance prescriptions
Dr. RG	304
Dr. DS	10
Dr. LR	29
Dr. Y. Mehrabi	3
Dr. A. Lipkin	1
Dr. J. barcena	1
Dr.H. Florian	1
Dr. I. Gorokhov	4
Total	353

41. During the inspection the inspectors located several prescriptions dispensed under the following prescribers: Dr. RG, Dr. JW, Dr.. DS and Dr. LR, Dr. I. Gorokhov, Dr. H. Florian, Dr. J. Barcena and Dr. Y. Mehrabi which were not reported to CURES. The inspectors asked the followings:

Question: How often does the pharmacy report prescription for a Schedule II, III or IV controlled substance to the Department of Justice (CURES/ Atlantic Associates, Inc)?

Answer: Every Tuesday, RX30 (Pharmacy's dispensing software) would automatically transmit to CURES. He received a fax from RX30 confirming his CURES transmission was successful, however, he did not keep such records.

Question: Why prescription for Dr. RG, JW and DS were not reported to CURES?

Answer: Respondent PIC was not sure. He further denied having any business relationships with Dr. RG, JW and DS.

42. The inspectors inquired the followings:

Question: Is your computer software the primary source of record keeping and maintenance in this pharmacy? If not, what is?

Answer: Yes.

Question: Is the following statement true or false: The electronic computer record of dispensed prescriptions stored in the pharmacy software system is a true and accurate representation of the hard copy (paper) prescription record?

Answer: True.

Question: What steps do you take to satisfy your corresponding responsibility to fill only medically legitimate controlled substance prescriptions?

Answer: Respondent PIC filled controlled substance prescriptions for regular patients, contacted the prescriber's office (phone number located on the prescription) for new patients, he did not check CURES and was unable to access CURES since he could "not figure out" his DEA number and he thought having access to CURES was "optional." Respondent PIC explained that he dispensed any Control Substance Schedule II prescription if it had the following criteria: Batch Number, Serial Number, and Prescriber's information: Name, address, DEA and NP.

Question: Is prescriber or patient distance a factor to be considered.

Answer: Respondent PIC dispensed prescriptions for patients who were within maximum 5 miles away and he accepted prescriptions from prescribers within 4-5 miles radius. However, the inspectors located several prescriptions with incomplete directions or no directions. The inspectors inquired whether he verified the directions or how he determined the directions? Respondent PIC "guessed" the directions and he did not contact the prescriber's office. If he had contacted the prescriber, he would make a notation on the prescription.

Question: Why did you dispense two prescriptions with the same patient name, address, doctor and medication but different dates of birth.

Answer: “I guess, I did not notice" and considered one of the patients to be "junior.”

Question: Why did you accept and dispense Controlled Substance Schedule II prescriptions from prescribers farther than 5 miles?

Answer: "In the past 6 months I stopped accepting prescriptions that were more than 5 miles." Respondent PIC dispensed around four to five Controlled Substance Schedule II prescriptions a day and primarily dispensed medications for hypertension and diabetes. Respondent PIC claimed he exercised his corresponding responsibility by speaking to the patient and advising and "discouraging" the patient from taking the controlled substance. However, Respondent PIC explained "As long as the doctor wrote the prescription, I would dispense the medication and only contact the prescriber if the patient was new to the pharmacy." In regards to different patients receiving the same medication with the same directions, Respondent PIC explained "I did not know." In reference to dispensing prescriptions with prescribers' distance being 50 miles away, Respondent PIC explained that if the patient was near (4-5 miles away from the pharmacy) he dispensed the prescription.

43. The inspectors described to Respondent PIC that some of the Controlled Substance Schedule II prescriptions appeared fraudulent, Respondent PIC claimed he was not aware and thought the prescriptions were legitimate.

44. Respondent PIC admitted selling: 60 oxycodone 30 mg for $34; 30 Hydrocodone/ APAP 10/325 mg for $21 to $24; 120 ml of Promethazine Codeine Syrup for 12. However, he claimed he stopped dispensing Alprazolam 2 mg since 2018.

45. Respondent PIC explained that patients brought hard copy prescriptions to the Pharmacy, the prescriptions were picked up by patients or their caregiver. He only delivered to one patient. Patients could only pickup their controlled substance prescription if they presented their driver's license. If they were new patients, he also verified the prescriptions using the patient's driver license.

46. When asked what he considered a safe dose for the medications, Respondent PIC stated the following: "*As long as the doctor wrote the prescription" he would dispense it*. He considered the following doses to be safe: (1) Promethazine and Codeine, 120 ml a week; (2) Oxycodone, 30 mg, once a day for quantity 30 tablets a month. Respondent PIC explained he had occasionally

contacted the prescribers regarding prescriptions higher than the amounts described above. He noticed the prescriber would stop for a short period of time. Either way he stated *he dispensed the prescriptions since the prescriber wrote it.*

47. When asked whether he had observed any "doctor shopping" or suspicious activity, Respondent PIC responded in negative.

48. During the inspection PIC Kim voluntary surrendered the pharmacy's DEA registration to the DEA agents.

49. At the conclusion of the inspection, Inspector E.D. went over the inspection report with Respondent PIC, and issued several of the violations, and requested additional documents related to the investigation.

50. The review of Respondent Pharmacy's CURES data for the controlled substance prescriptions dispensed between July 1, 2017 and July 24, 2019 revealed that in 2017 Respondent Pharmacy reported a total of 231 prescriptions to CURES, in 2018 Respondent Pharmacy reported a total of 100 prescriptions to CURES, and in 2019 Respondent Pharmacy reported a total of 4 prescriptions to CURES.

51. Using the CURES data and the provided DUR, Inspector E.D. prepared a table comparing Respondent Pharmacy's dispensing data and CURES between July 1, 2017 and July 24, 2019.

Prescriber	DEA Number	Number of RX dispensed	Number of RX reported to CURES	Variance
Dr. R.G	BG9659624	969	0	969
Dr. D.S	BS8233241	61	0	61
Dr. J.W.	FW2768921	304	6	298
Dr. L.R.	AG4488575	29	0	29
Total		1,363	6	1,357

52. Inspector E.D. determined that 2,630 of prescription of Controlled Substance Scheduled II to IV were dispensed at Respondent Pharmacy between July 1, 2017 and July 24, 2019, however, only 335 prescriptions were reported to the CURES.

53. Inspector E.D. reviewed the dispensing profiles for Dr.s R.G, J.W., and D.S., using the DUR provided by Respondent PIC. She identified irregularities in the prescribing profiles of the above referenced prescribers, as set forth in below tables.

Medication prescribed by **Dr. R.G.**	Drug Schedule	Payment Method	Number of Prescriptions	Percent of Total Prescriptions
Promethazine- Codeine Syrup	5	cash	843	46.32%
Hydrocodone APAP 10-325	2	cash	625	34.34%
Oxycodone HCL 30 mg tablet	2	cash	147	8.08%
Alprazolam 2 mg tablet	4	cash	142	7.80%
Amphetamine salts 30 mg tablet	2	cash	19	1.04%
Dextroamp-Amphetamine 30 mg	2	cash	17	.93%
Carisoprodol 350 mg tablet	4	cash	14	.77%
Diazepam 10 mg tablet	4	cash	4	.22%
Promethazine-DM Syrup		cash	2	.11%
Indomethacin 50 mg capsule		cash	2	.11%
Cephalexin 500 mg cap		cash	2	.11%
Promathazine 6.25 mg/5ml syrup		cash	1	.05%
Cephalexin 500 mg capsule		cash	1	.05%
Hydrocodone/APAP 5/500 tab	2	cash	1	.05%
Total			1,820	100%

54. Details of **Dr. R.G**.'s prescribing authority revealed the followings:

- There was a total of fourteen different medications dispensed at NCP under the prescribing authority of Dr. RG.
- About 99.5% of the prescriptions dispensed were for controlled substances.
- The top three most dispensed prescriptions under the prescribing authority of Dr. RG were: promethazine and codeine syrup, hydrocodone-AP AP 10/325 mg and oxycodone 30 mg.
- About 46.32% of Dr. RG's prescriptions were written for promethazine and codeine syrup. This medication has only one available dose and it is commonly prescribed treat cough for a short duration. It was dispensed to approximately 72 patients multiple times. Approximately 843 prescriptions were written for promethazine and codeine syrup. All the patients received promethazine and codeine syrup for quantity of 120 ml.
- About 34.3% of Dr. RG's prescriptions were written for hydrocodone-APAP 10/325. It was dispensed to approximately 72 patients. Hydrocodone-APAP 10/325 mg tablets are available in 2.5-325, 5-325, 7.5-325 and 10/325 mg tablets. Approximately 625 prescriptions were written for hydrocodone-AP AP 10/325 mg tablets and there were no prescription written for the other strengths.
- About 8% of Dr. RG's prescriptions were written for oxycodone 30 mg tablets. These prescriptions of oxycodone 30 mg tablets were dispensed to approximately 25 patients. Oxycodone immediate-release is available in 5, 10, 15, 20, and 30 mg tablets. All of the patients received highest dose which was oxycodone 30 mg.
- About 7.8% of Dr. RG's prescriptions were written for alprazolam 2 mg tablets. Alprazolam immediate-release is available in 0.25, 0.5, 1 and 2 mg tablets.
- All of Dr. R.G.’s prescriptions were purchased in "cash," meaning without the financial aid of prescription insurance or discount card. Patients typically prefer to pay for prescription medications with prescription insurance. About 79.94% of all prescriptions (controlled and non-controlled) filled at NCP from 07/01/2017 to 07/24/2019 were billed to a plan. Therefore, this payment pattern was a factor of

irregularity. Promethazine-codeine, hydrocodone-AP AP 10/325 mg, oxycodone 30 mg and alprazolam 2 mg: (1) are considered commonly abused controlled substances; (2) were dispensed at the highest strength available; (3) were dispensed for cash; (4) Made up an unusually large portion of one prescriber's prescription profile. Prescribers commonly aim to treat patients with the lowest effective dose of medications in order to minimize the risk of side effects and toxicity from the medications. It is standard practice to initiate therapy on a low dose of medication and increase the dose if necessary. Therefore, Dr. R.G.'s frequent prescribing of the highest available dose of top three medication was a factor of irregularity.

55. In reviewing Dr. R.G.'s controlled substances prescribed, Inspector E.D. noted the following additional red flags for the verifying pharmacist:

- Multiple instances when Respondent Pharmacy processed multiple prescriptions for promethazine-codeine, hydrocodone-APAP 10/325 mg and oxycodone 30 mg from Dr. R.G. on the same day issued to unique patients. Often these prescriptions were assigned consecutive prescription numbers. This pattern of irregularity is a red flag for the verifying pharmacist.
- The same patients received controlled substance on a monthly basis.This pattern of irregularity is a red flag for the verifying pharmacist.
- In addition, in reviewing Dr. R.G.'s 304 prescriptions failed to comply with the security features outlined in Code of Health and Safety Code Section 11164 and 11162.1.

56. Inspector E.D. accessed the California Board of Medicine's public database online to verify the status of Dr. R.G.'s license and his self-reported areas of practice were Family Medicine, Emergency Medicine, and Internal Medicine. However, Dr. R.G.'s prescribing profile is inconsistent with typical Family Medicine, Emergency Medicine, and Internal Medicine. This was a factor of irregularity.

57. Dispensing records and prescription documents review of Dr. D.S. are set forth below:

Medication prescribed by **Dr. D.S.**	Drug Schedule	Payment Method	Number of Prescriptions	Percent of Dr. D.S.' Total Prescriptions
Promethazine-Codeine Syrup	5	cash	79	50.72%
Hydrocodone-APAP 10/325	2	cash	37	26.81%
Oxycodone HCL 30 mg tablet	2	cash	24	17.39%
Prezcobix 800-150 mg tabs		other	3	2.17%
Triumeq 600-50-300 mg tabs		other	2	1.45%
Ibuprofen 400 mg tab		cash	2	1.45%
Total			138	100%

58. The review of Dr. D.S.' prescribing profile revealed the following:

- There was a total of six different medications dispensed at NCP under the prescribing authority of Dr. D.S.
- About 94.93% of the prescriptions dispensed were for controlled substances.
- The top three most dispensed prescriptions under the prescribing authority of Dr. DS were: promethazine and codeine syrup, hydrocodone-APAP 10/325 mg and oxycodone 30 mg.
- About 50.72% of Dr. D.S.' prescriptions were written for promethazine and codeine syrup. Promethazine and codeine syrup has only one available dose and it is commonly prescribed to treat cough for short duration. It was dispensed to approximately 4 patients multiple times. Approximately 70 prescriptions were written for promethazine and codeine syrup for the four patients.
- All the patients received promethazine and codeine syrup for a quantity of 120 ml.

- About 26.81 % of Dr. D.S.' prescriptions were written for hydrocodone-APAP 10/325 mg tablets. It was dispensed to approximately four patients. Hydrocodone-APAP 10/325 mg tablet is available in 2.5-325, 5-325, and 7.5-325 mg tablets.
- Approximately 37 prescriptions were written for hydrocodone-APAP 10/325 mg tablets and no prescription were written for the other strengths.
- About 17.39% of Dr. D.S.' prescriptions were written for oxycodone 30 mg tablets. These prescriptions of oxycodone 30 mg tablets were dispensed he same four patients who received promethazine and codeine syrup. Oxycodone immediate-release is available in 5, 10, 15, 20, and 30 mg tablets. All of the patients received highest dose which was oxycodone 30 mg.
- All of Dr. D.S.' prescriptions for controlled substance were purchased in "cash," meaning without the financial aid of prescription insurance or discount card. Approximately 79 .94% of all prescriptions (controlled and non-controlled) filled at Respondent's Pharmacy from July 1, 2017 to July 24, 2019 were billed to a plan. Therefore, this payment pattern was a factor of irregularity. Promethazine-codeine, hydrocodone-APAP 10/325 mg, oxycodone 30 mg: (1) Are considered commonly abused controlled substances; (2) Were dispensed at highest strength available; (3) Were dispensed for "cash"; (4) Made up a large portion of one prescriber's prescription profile. Dr. D.S.' frequent prescribing of the highest available dose of top three medication was a factor of irregularity.

59. In reviewing Dr. D.S.' controlled substance prescription profile, the following additional red flag were noted:

- Multiple instances when Respondent Pharmacy processed multiple prescriptions for promethazine-codeine, hydrocodone-APAP 10/325 mg and oxycodone 30 mg from Dr. D.S. on the same day issued to unique patients. Often these prescriptions were assigned consecutive prescription numbers, which is a red flag for the verifying pharmacist.

- Same four patients received either one of the top three medications on a monthly basis. This pattern of irregularity is a red flag for the verifying pharmacist.
- In addition, in reviewing Dr. D.S.' ten prescription they failed to comply with the security features outlined in Code of Health and Safety Code Section 11164 and 11162.1. The California Board of Medicine's public database online (BreEZe) indicated that Dr. D.S.'s license self-reported areas of practice were Family Medicine and Emergency Medicine. However, Dr. D.S.'s prescribing profile is inconsistent with typical Family Medicine and Emergency Medicine. This was a factor of irregularity.

60. The dispensing record and prescription documents review of Dr. L.R. revealed the following:

Medications prescribed by **Dr. L.R.**	Drug Schedule	Payment Method	Number of Prescriptions	Percent of Dr. L.R.'s Total Prescriptions
Hydrocodone-APAP 10-325	2	cash	20	27.03%
Promethazine-Codeine Syrup	5	cash	11	14.86%
Clonidine HCL 0.1 mg tablet		cash	10	13.51%
Benzepril HCL 40 mg tab		cash	10	13.51%
Cephalexin 500 mg capsule		cash	9	12.16%
Oxycodone HCL 30 mg tablet	2	cash	6	8.11%
Ibuprofen 800 mg tablet		cash	4	5.41%
Diazepam 10 mg tablet	4	cash	2	2.70%
Dextroamp-Amphetamine 30 mg	2	cash	1	1.35%
Promethazine 6.25 mg/5 ml syrup		cash	1	1.35%
Total			74	100%

61. There was a total of ten different medications dispensed at NCP under the prescribing authority of Dr. L.R.:

- About 54.05% of the prescriptions dispensed were for controlled substances.
- The top two most dispensed prescriptions, under the prescribing authority of Dr. L.R., were: hydrocodone-APAP 10/325 mg and promethazine and codeine syrup.
- About 27.03% of Dr. L.R.'s prescriptions were written for hydrocodone-APAP 10/325 mg tablets: (1) It was dispensed to approximately 17 patients; (2) hydrocodone-APAP 10/325 mg tablet is available in 2.5-325, 5-325, and 7.5-325 mg tablets; (3) Approximately 20 prescriptions were written for hydrocodone-APAP 10/325 mg tablets and no prescription written for the other strengths. All 17 patients received the highest strength.
- About 14.86% of Dr. L.R.'s prescriptions were written for promethazine and codeine syrup: (1) promethazine and codeine syrup has only one available dose and it is commonly prescribed to treat cough for short duration: (2) It was dispensed to approximately 11 patients multiple times; (3) Approximately 11 prescriptions were written for promethazine and codeine syrup; (4) All the patients received promethazine and codeine' syrup for quantity of 120 ml.
- All of Dr. L.R.'s prescriptions for controlled substance were purchased in "cash," meaning without the financial aid of prescription insurance or discount card. Approximately 79.94% of all prescriptions (controlled and non-controlled) filled at Respondent Pharmacy from July 1, 2017 to July 24, 2019 were billed to a plan. Therefore, this payment pattern was a factor of irregularity. Further, Promethazine-codeine and hydrocodone-APAP 10-325 mg are considered commonly abused controlled substance. They were dispensed at highest strength available by the Respondents. They were dispensed for "cash." They made up a large portion of one prescriber's prescription profile. Prescribers commonly aim to treat patients with the lowest effective dose of medications in order to minimize the risk of side effects and toxicity from the medications. It is standard practice to initiate therapy on a low

dose of medication and increase the dose if necessary. Therefore, Dr. L.R.'s frequent prescribing of the highest available dose of top three medication was a factor of irregularity.

62. In reviewing Dr. L.R's controlled substance prescribed, the following additional red flags for the verifying pharmacist are noted: (1) Multiple instances when Respondent pharmacy processed multiple prescriptions for promethazine-codeine, hydrocodone-APAP 10/325 mg from Dr. L.R. on the same day issued to unique patients. Often these prescriptions were assigned consecutive prescription numbers. This evidence a pattern of irregularity, which is a red flag for the verifying pharmacist; (2) Further, in reviewing Dr. L.R.'s 29 prescription photographs, they all did not comply with the security features outlined in Code of Health and Safety Code Section 11164 and 11162.1. The California Board of Medicine's public database verified the status of Dr. L.R.'s California Physician and Surgeon License and his self-reported areas of practice was Pain Medicine. Dr. L.R.'s prescribing profile is inconsistent with typical Pain Medicine, specifically, for prescribing cough medications such as promethazine and codeine. This was a factor of irregularity.

63. The dispensing record and prescription documents review of Dr. J.W. revealed the following:

Medications prescribed by **Dr. J.W.**	Drug Schedule	Payment Method	Number of Prescriptions	Percent of Dr. J.W.'s Total Prescriptions
Promethazine-Codeine Syrup	5	cash	313	46.58%
Hydrocodone-APAP 10-325	2	cash	228	33.93%
Carisoprodol 350 mg tablet	4	cash	39	5.80%
Amoxicillin 500 mg capsule		cash	34	5.06%

Diazepam 10 mg tablet	4	cash	12	1.79%
Merepidine 50 mg tablet	2	cash	12	1.79%
Azithromycin 250 mg tablet		cash	11	1.64%
Suboxone 8 mg-2 mg SL Film	3	Other (6)/ cash (1)	7	1.04%
Suboxone 4-1 mg film	3	other	5	0.74%
Zetia 10 mg tablet		other	3	0.45%
Prometahzine- DM syrup		cash	1	0.15%
Tramadol HCL 50 mg tablet	4	cash	1	0.15%
HM low dose Aspirin EC 81M		other	1	0.15%
Amlodipine Besylate 5 mg TA		other	1	0.15%
Banophen 25 mg capsule		cash	1	0.15%
Aspirin 81 mg TBEC		cash	1	0.15%
Albuterol Sulfate HFA 108		cash	1	0.15%
Cyclobenzaprine 10 mg tablet		cash	1	0.15%
Total			672	100%

64. Details of Dr. J.W.'s prescribing profile included the following:

- There was a total of 18 different medications dispensed at Respondent pharmacy under the prescribing authority of Dr. J.W.
- About 91.82% of the prescriptions dispensed were for controlled substances.
- The top two most dispensed prescriptions under the prescribing authority of Dr. J.W. were promethazine and codeine syrup and hydrocodone-AP AP 10/325 mg.
- About 46.58% of Dr. J.W.'s prescriptions were written for promethazine and codeine syrup; (1) promethazine and codeine syrup has only one available dose and it is commonly prescribed to treat cough for short duration; (2) It was dispensed to approximately 38 patients multiple times; (3) Approximately 313 prescriptions were

written for promethazine and codeine syrup; (4) All the patients received promethazine and codeine syrup for a quantity of 120 ml.

- About 33.93% of Dr. J..W's prescriptions were written for hydrocodone-APAP 10/325 mg tablets: (1) It was dispensed to approximately 36 patients; (2) Hydrocodone-APAP 10/325 mg tablet is available in 2.5-325, 5-325, and 7.5-325 mg tablets; (3) Approximately 228 prescriptions were written for hydrocodone-AP AP 10/325mg tablets and no prescription written for the other strengths combined.
- All of Dr. J.W.'s prescriptions for controlled substances were purchased in "cash," (except for 6 prescriptions for Suboxone 8 Mg-2 Mg SL Film) meaning without the financial aid of prescription insurance or discount card. As previously stated, patients typically prefer to pay for prescription medications with prescription insurance. About 79 .94% of all prescriptions (controlled and non-controlled) filled at NCP from July 1, 2017 to July 24, 2019 07/01/2017 to 07/24/2019 were billed to a plan. Therefore, this payment pattern was a factor of irregularity. Promethazine-codeine and hydrocodone-APAP 10/325 mg: (1) was considered commonly abused controlled substance: (2) were dispensed at highest strength available; (3) were dispensed for "cash;" (4) made up a large portion of one prescriber's prescription profile. Prescribers commonly aim to treat patients with the lowest effective dose of medications in order to minimize the risk of side effects and toxicity from the medications. It is standard practice to initiate therapy on a low dose of medication and increase the dose if necessary. Therefore, Dr. J.W.'s frequent prescribing of the highest available dose of top two medication was a factor of irregularity.

65. In reviewing Dr. J.W.'s controlled substance prescribed, the following additional red flags for the verifying pharmacist: (1) multiple instances when NCP processed multiple prescriptions for promethazine-codeine, hydrocodone-APAP 10/325 mg from Dr. J.W. on the same day issued to unique patients. Often these prescriptions were assigned consecutive prescriptions confirming this pattern of irregularity, which is a red flag for the verifying pharmacist; (2) Same patients received controlled substance on a monthly basis, which evidence .

this pattern of irregularity, which is a red flag for the verifying pharmacist: (3) The California Board of Medicine's public database verified the status of Dr. J.W.'s California Physician and Surgeon License self-reporting area of practice as a neurologist; (4) Dr. J.W.'s prescribing profile is inconsistent with typical practice of a neurologist, in prescribing cough medications such as promethazine and codeine syrup. This was a factor of irregularity.

66. On or about October 1, 2019, Inspector E.D. sent letters to Dr. J.W., Dr. D.S., Dr. R.G. and Dr. L.R. to their addresses of record listed on the Medical Board's website regarding the prescriptions dispensed at Respondent Pharmacy, requesting the prescriber to verify some the prescriptions which were dispensed at Respondent Pharmacy, asking the prescribers to review the prescribing history and prescription images and determine if they actually wrote the prescriptions in question.

67. On or about October 16, 2019, Inspector E.D. spoke with Dr. L.R. who stated he had received the inspector's letter and explained that all the mentioned prescriptions were "unauthorized" and "fraudulent" prescriptions. He further explained the prescriptions forms were not his forms and he primarily sent prescriptions for controlled substance electronically. He further explained that he had "never" been contacted by Respondent Pharmacy, and the signatures were not his. Inspector E.D. later received a signed statement from Dr. L.R. stating he did not prescribe the enclosed prescriptions, he did not recognize the enclosed prescriptions, and he did not recall being contacted by Respondent Pharmacy. Out of the 74 prescriptions dispensed under Dr. L.R.'s prescribing authority, 56 unauthorized prescriptions (29 prescriptions of which were for controlled substance) had a different signature than Dr. L.R.'s authentic signature.

68. On or about October 16, 2019, Inspector E.D. received a signed statement from Dr. D.S. stating she did not prescribe the enclosed prescriptions and the signatures were not hers, that she did recognize the enclosed prescriptions forms from a clinic she used to practice in 2018 and she was "never" contacted by Respondent Pharmacy. The ten (10) unauthorized prescriptions (all for controlled substance) all had a different signature than Dr. D.S.' authentic signature.

69. On or about October 28, 2019, Inspector E.D. received a call and a facsimile from Dr. J.W. who stated he had authorized the prescriptions, however, he was not contacted by Respondent Pharmacy to discuss any aspects of the prescriptions.

70. Based on Dr. L.R. and Dr. D.S.' statements, Respondent Pharmacy dispensed a total of 66 prescriptions (56 under the prescribing authority Dr. L.R .and 10 under the prescribing authority Dr. D.S.)

71. Inspector E.D. calculated the prescriber distance from the Respondent Pharmacy as follow: (1) Dr. D.S. as 32.2-35.5 miles; (2) Dr. R.G. as 3.7 miles (3) Dr. L.R. as 5.5-6.l miles; and (4) Dr. J.W. as 3.5-3.6 miles. It was a factor of irregularity for patients in urban areas, well served by pharmacies and physicians, to travel around 35 miles between Dr. DS' office and Respondent Pharmacy.

72. Respondent Pharmacy's DUR between July 1, 2017 and July 24, 2019 documented that: (1) there were approximately 123 patients who received controlled substance prescriptions at Respondent Pharmacy under the prescribing authority of Dr. R.G.., Dr. D.S., Dr. L.R. and Dr. J.W.; (2) out of 123 patients there were 38 patients within cities located more than 18 miles from Respondent Pharmacy's address:

Patient's City	Number of prescriptions	Distance between the patient's location and Respondent's Pharmacy's location
Bellflower	46	37
Carson	8	37
Compton	8	38
Culver City	8	19
Inglewood	40	24
La Puente	2	40

Lancaster	43	53
Long Beach	345	18
Palmdale	92	46
Rialto	40	68
Thousand Oaks	25	29
Victorville	16	92
Total	711	

73. These patients received commonly abused controlled substances from Dr. R.G., Dr. D.S., Dr. L.R., and Dr. J.W. and drove excessive distances to receive their medications from Respondent Pharmacy when there were other pharmacies located within their corresponding cities. It was a significant factor of irregularity for these patients to be willing to travel the long distances listed above, each way, to obtain controlled substances.

74. Using Respondent Pharmacy's DUR between July 1, 2017 and July 24, 2019, Inspector E.D. determined instances when multiple patients with the same or similar addresses received similar drug therapy. This was a factor of irregularity because it would be unusual for multiple people in the same household to require the same treatment for the same conditions. By way of example: (1) patients having the same address ("8-- W. 105th St, Los Angeles, CA"), first name and last name (patients' initials "AC"), however, they had different date of birth; (2) patients having the same address ("9--- Haskell Ave, North Hills, CA"), same date of birth, however, they had different first and last name; (3) patients having the same address ("1---- Hagar St, Sylmar, CA"), same first and last name, except one with "JR", and different date of births; (4) at least four patients with controlled substance prescriptions under Dr. R.G. and Dr. L.R. had an address of ("1---- Hagar St, Sylmar, CA").

FIRST CAUSE FOR DISCIPLINE

Failure to Comply with Corresponding Responsibility in Determining the Legitimacy of a Prescription)

74. Respondent Pharmacy and Respondent PIC are subject to disciplinary action under

California Code of Regulations section 1761, subd. (a) in conjunction with Health and Safety Code section 11153, subd (a), and Bus. Prof. C. §§4113, 4156, 4301, 4301(d), 4301 (j), 4301(o), 4302, 4035 and 4306.5, in conjunction with Health & Safety C. §11153, subdivision (a), and pursuant to *Vermont & 110th Medical Arts v. Board of Pharmacy* (1981) 125 Cal.App.3d 19 (hereinafter referred as *Vermont*), pursuant to *Sternberg v. Board of Pharmacy* (2015) 239 Cal. App. 4th 1159 (hereinafter referred as Sternberg), pursuant to the Board of Pharmacy's Precedential Decision No. 2013-01 (*Board of Pharmacy* v. Pacifica Pharmacy Corporation, et al., (2012) Case No. 3802, OAH No. 2011010644) (hereinafter referred as *Pacifica*), and pursuant to *Arenstein v. Cal. State Bd. of Pharmacy* (1968) 265 Cal.App.2d 179, 192, on the grounds of unprofessional conduct because Respondents failed to exercise or implement their best professional judgment or their corresponding responsibility to ensure that controlled substances are dispensed for a legitimate medical purpose, in that Respondents dispensed prescriptions which contain significant error, omission, irregularity, uncertainty, ambiguity or alteration. Respondents failed to contact the prescriber to obtain the information needed to validate the prescription. 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 and in filling these prescriptions.

75. Specifically, from July 1, 2017 to July 24, 2019, Respondents dispensed approximately 2,600 Controlled Substance Schedules II-V prescriptions under the prescribing authority of Drs. R.G., D.S., L.R., and J.W. The investigation determined Respondents failed to fulfill their corresponding responsibility in filling prescriptions written by these prescribers in the presence of the following objective factors suggesting the prescriptions were not written for legitimate purposes:

a. The majority of the prescriptions written by the listed prescribers were purchased in "cash," meaning without the financial aid of prescription insurance or discount card. 100% of the controlled substance prescriptions under the prescribing authority of Drs. R.G., D.S., and L.R., and 90.77% of controlled substance prescriptions under the prescribing authority of Dr. J.W. , were paid in "cash".

b. The prescribing profiles of the listed prescribers were limited with a .small number of controlled substances accounting for a relatively large percentage of their total prescribing.

- About 99.5% of Dr. R.G.'s prescriptions dispensed were for controlled substances.
- About 94.93% of Dr. D.S.' prescriptions dispensed were for controlled substances.
- About 54.05% of Dr. L.R.'s prescriptions dispensed were for controlled substances.
- About 91.82% of Dr. J.W.'s prescriptions dispensed were for controlled substances.

c. All of the prescriptions written by the listed prescribers for oxycodone, hydrocodone-containing products, promethazine-codeine syrup and alprazolam contained the highest available dose of each medication.

d. 304 prescriptions written by Dr. R.G., 10 prescriptions written by Dr. D.S., and 22 prescriptions written by Dr. L.R. lacked the security features described pursuant to Health and Safety Code Section 11164, 11162.1.

e. There were several instances when multiple prescriptions written by the listed prescribers were dispensed on the same day at Respondent Pharmacy. By way of example, 12 prescriptions for controlled substance were-dispensed on August 10, 2018, under the prescribing authority of Dr. R.G.

f. There were multiple patients with the same or similar addresses who received similar drug therapy. For example:

- Patients having the same address ("8-- W. 105th St, Los Angeles, CA"), first name and last name (patients' initials "AC"), however, they had different dates of birth.
- Patients having the same address ("9--- Haskell Ave, North Hills, CA"), same date of birth ("4/20/1965"), however, they had different first and last names.
- Patients having the same address ("12965 Hagar St, Sylmar, CA"), same first and last name except one with "JR" and different dates of birth. At least 4 patients with

controlled substance prescriptions under Dr. R.G. and Dr. L.R. had an address of ("1---- Hagar St, Sylmar, CA").

g. There were at least 38 patients who travelled excessive distances (more than 18 miles) between the prescribing office and the pharmacy to obtain controlled substance from Respondent Pharmacy.

h. Respondent Pharmacy failed to produce documentation to indicate efforts of a pharmacist to confer with the prescriber to discuss the irregularities or objective factors described above.

76. Failing to practice corresponding responsibility obligations in dispensing controlled substance is a violation of Health and Safety Code Section 11153 subdivision (a). Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 25-73, inclusive, as though set forth fully.

SECOND CAUSE FOR DISCIPLINE

(Dispensing Controlled Substances Written on Prescriptions Containing any Significant Error, Omission, Irregularity, Uncertainty, ambiguity or Alteration)

77. Respondent Pharmacy and Respondent PIC are subject to disciplinary action under Health & Safety Code sections 11164 and 11162.1, in conjunction with California Code of Regulations, Title 16, section 1761, subdivision (a) in that Respondents dispensed approximately 353 controlled substance prescriptions written on prescription documents which did not conform to the requirements of Health and Safety Code Section 11162.1 as follows: approximately 304 prescriptions written by Dr. R.G., 10 prescriptions written by Dr. D.S., 29 prescriptions written by Dr. L.R., 3 prescriptions written by Dr. Y.M., 1 prescription by Dr. A.L., 1 prescription by Dr. J.B., 1 prescription by Dr. H.F., and 4 prescriptions by Dr. R.G. prescriptions. Dispensing controlled substance prescriptions written on prescriptions which contain any significant error, omission, irregularity, uncertainty, ambiguity or alteration is a violation of Health and Safety Code Section 11164 as it relates to Health and Safety Code Section 11162. l and California Code of Regulations Section 1761. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 25-73, inclusive, as though set forth fully.

THIRD CAUSE FOR DISCIPLINE

(Failure to Report CURES to the Department of Justice)

78. Respondent Pharmacy and Respondent PIC are subject to disciplinary action under Health & Safety Code sections 11165, subdivision (d), and Code of Federal Regulations, Title 21, sections 1308.12, 1308.13 and 1308.14, in that Respondents failed to properly transmit CURES data to the Department of Justice for the period between July 1, 2017 and July 24, 2019. Respondents dispensed approximately 2,295 Schedule II, III, or IV controlled substance prescriptions between July 1, 2017 and July 24, 2019 which were not reported to the CURES program within 7 days of being dispensed. Further, Respondents stopped reporting to CURES between April 5, 2019 and July 24, 2019. Failing to report to CURES to the Department of Justice is a violation California Health and Safety Code 11165 subdivision (d). Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 25-73, inclusive, as though set forth fully.

FOURTH CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs or Devices Prohibited Without Prescriptions)

79. Respondent Pharmacy and Respondent PIC are subject to disciplinary action under Business and Professions Code section 4059, subdivision (a), in that Respondents dispensed approximately 66 prescriptions under the alleged prescribing authority of Dr. L.R. and Dr. D.S. without the prescribers' authorization. Furnishing any dangerous drug without prescription from a physician is a violation of Business and Professions Code 4059(a). Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 25-73, inclusive, as though set forth fully.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct- Billing Insurance Company for Prescriptions not dispensed)

80. Respondent Pharmacy and Respondent PIC are subject to disciplinary action under Business and Professions Code sections 4301, subdivision (f), and 4306.5, subdivision (a) , in that Respondents billed patients' insurances for following prescriptions which the patient did not receive. The prescriptions were kept at Respondent Pharmacy.

RX number	Medication	Fill Date	Insurance
188483	One touch Ultra Test Strips	3/30/2018	Commercial
195271	Prednisone 10 mg tablet	5/23/2019	Commercial
188273	Ferrous Sulfate 325 mg tablet	2/27/2019	Commercial
182054	Amlodipine Besylate 5 mg tablet	10/5/2017	Commercial
194531	Amlodipine Besylate 10 mg tablet	4/5/2019	Medicare
195151	Simvastatin 20 mg tablet	5/15/2019	Commercial
194926	Glimepiride 4 mg tablet	5/31/2019	Commercial
194109	Albuterol Sulfate HFA 108	3/11/2019	Commercial

81. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 25-73, inclusive, as though set forth fully.

SIXTH CAUSE FOR DISCIPLINE

(Misbranded and Adulterated Drugs)

82. Respondent Pharmacy and Respondent PIC are subject to disciplinary action under Health and Safety Code sections 111440, 111295, 111305, in conjunction with Business and Professions Code section 4169 (a) (2) and (3), in that Respondents kept as part of its active inventory several expired medications, unlabeled or not properly labeled dangerous drugs. This was a violation of Health and Safety Code sections 111440, 111295, 111305 and Business and Professions Code 4169 (a) (2) and (3) for holding as part of the pharmacy's active drug stock misbranded and adulterated drugs, as defined by Health and Safety Code 111250, 111330, 111335, 111260, and 111340. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 25-73, inclusive, as though set forth fully.

SEVENTH CAUSE FOR DISCIPLINE

(Operational Standard and Security)

83. Respondent Pharmacy and Respondent PIC are subject to disciplinary action under California Code of Regulations, Title 16, section 1714 (b) and (c), in that Respondents'

medications, shelves and invoices, were not maintained in a clean and orderly condition. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 25-73, inclusive, as though set forth fully.

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Label Prescriptions with the Manufacturer's Trade Name of the Drug)

84. Respondent Pharmacy and Respondent PIC are subject to disciplinary action under California Code of Regulations, Title 16, section 1707.5, subdivision (a)(l)(B), in that Respondents had labeled several prescriptions in the waiting-bin which did not comprises manufacturer's trade name of the drug, or the generic name and the statement "generic for " to be at least 50 percent of the label, at least a 12-point sans serif typeface. This was a violation for not labeling prescriptions with the manufacturer's trade name of the drug. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 25-73, inclusive, as though set forth fully.

NINTH CAUSE FOR DISCIPLINE

(Accepting Unwanted Prescription Drugs from Patients as a Collector Site with the DEA without Being Registered with the DEA)

85. Respondent Pharmacy and Respondent PIC are subject to disciplinary action under California Code of Regulations, Title 16, section 1776, in that Respondents accepted several unwanted prescription drugs back from patients to discard without being registered with the Drug Enforcement Administration (DEA) as a collector site for drug take-back service. Accepting unwanted prescription drugs from patient(s) with being registered as collector site with the DEA is a violation of California Code of Regulations 1776. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 25-73, inclusive, as though set forth fully.

TENTH CAUSE FOR DISCIPLINE

(Failing to Maintain Inventories and Records of Schedule II, II, IV and V Controlled Substances)

86. Respondent Pharmacy and Respondent PIC are subject to disciplinary action under for Code of Federal Regulations, Title 21, section l304.04, subdivision (h), in that Respondent failed to maintain separately inventories and records of all controlled substances listed as Schedule II, III, IV, and V controlled substances. Further, prescription documents for Schedule II controlled substances filled on or about 2017 were not maintained at the pharmacy and were stored at Respondent PIC's residence. The pharmacy's DEA biennial inventory was located at Respondent PIC's residence. Failing to maintain inventories and records of Schedules II, III, IV, and V controlled substances separate from all other records of the pharmacy and for not storing paper prescriptions of Schedules II, III, IV, and Vat the pharmacy is a violation for Code of Federal Regulations, Title 21, section l304.04 (h). Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 25-73, inclusive, as though set forth fully.

ELEVENTH CAUSE FOR DISCIPLINE

(Failing to Record on the DEA Form the Dates Schedule II Controlled Substances Were Received)

87. Respondent Pharmacy and Respondent PIC are subject to disciplinary action under Code of Federal Regulations, Title 21, section 1305.13 (e), in that Respondents failed to record the dates on which the Controlled Substances Schedule II were received by the pharmacy. The table below illustrates the DEA Form 222 forms which were identified as incomplete.

Date Ordered	Invoice Number
2/22/2018	785134850
3/7/2018	7860198258
3/12/2018	7860922442
2/28/2018	7859024499
2/12/2018	7856247531
2/12/2018	7856247533

2/2/2018	7854820336
1/24/2018	7853043220
1/11/2018	7850859663
1/4/2018	7849566363
12/28/2017	7848467760
12/20/2017	7847128092
12/6/2017	7844606188
11/28/2017	8743069138
11/21/2017	7842030040
11/10/2017	7840041012
11/2/2017	7838825689

88. Failing to record on the DEA Form 222 the dates on which the Controlled Substances Schedule II were received is a violation of Code of Code of Federal Regulations, Title 21, section 1305.13 (e). Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 25-73, inclusive, as though set forth fully.

TWELFTH CAUSE FOR DISCIPLINE

(Failing to Join the Board's Email Notification List)

89. Respondent Pharmacy and Respondent PIC are subject to disciplinary action under Business Professions Code 4013, in that Respondents failed to join the board's email notification list within 60 days of obtaining a license or at the time of license renewal. Failing to join the board's email notification list within 60 days of obtaining a license or at the time of license renewal is a violation of Business Professions Code 4013. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 25-73, inclusive, as though set forth fully.

OTHER MATTERS

90. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 45171, issued to Ncrxone, Inc. dba New Century Pharmacy, Jason Myungjoon Kim, Jason

Myungjoon Kim 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 45171 is placed on probation or until Pharmacy Permit Number PHY 45171 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 Permit Number PHY 45171, issued to Ncrxone, Inc. dba New Century Pharmacy, Jason Myungjoon Kim;

2. Revoking or suspending Pharmacist License Number RPH 39008, issued to Jason Myungjoon Kim;

3. Prohibiting Ncrxone, Inc. dba New Century 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 45171 is placed on probation or until Pharmacy Permit Number PHY 45171 is reinstated if Pharmacy Permit Number 45171 issued to Ncrxone, Inc. dba New Century Pharmacy is revoked;

4. Prohibiting Jason Myungjoon Kim from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if years if Pharmacy Permit Number PHY 45171 is placed on probation or until Pharmacy Permit Number PHY 45171 is reinstated if Pharmacy Permit Number 45171 issued to Ncrxone, Inc. dba New Century Pharmacy is revoked;

5. Ordering New Century Pharmacy and Jason Myungjoon Kim 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

///

///

///

///

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

DATED: May 26, 2020

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

LA2020500767
accusation.docx