

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

**In the Matter of Accusation Against:**

**PRESTIGE PHARMACY, INC., DBA ST. PAULS PHARMACY 2,  
TRAMANH NU TON,**

**Pharmacy Permit No. PHY 50331,**

**and**

**TRAMANH NU TON,**

**Pharmacist License No. RPH 59598**

**Respondents**

**Agency Case No. 6886**

**OAH Case No. 2021020641**

**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 September 29, 2021.

It is so ORDERED on August 30, 2021.

BOARD OF PHARMACY  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

By 

Seung W. Oh, Pharm D  
Board President

1 ROB BONTA  
Attorney General of California  
2 ARMANDO ZAMBRANO  
Supervising Deputy Attorney General  
3 STEPHANIE J. LEE  
Deputy Attorney General  
4 State Bar No. 279733  
300 So. Spring Street, Suite 1702  
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*Attorneys for Complainant*  
7

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

12 In the Matter of the Accusation Against:

13 **PRESTIGE PHARMACY, INC., DBA ST.**  
14 **PAULS PHARMACY 2, TRAMANH NU**  
15 **TON**  
8809 Whitter Blvd.  
Pico Rivera, CA 90660

16 **Pharmacy Permit No. PHY 50331,**

17 **and**

18 **TRAMANH NU TON**  
12235 Beach Blvd. Ste. 104C  
19 Stanton, CA 90680

20 **Pharmacist License No. RPH 59598**

21 Respondents.

Case No. 6886

OAH No. 2021020641

**STIPULATED SURRENDER OF  
LICENSE AND ORDER**

As to Respondent Prestige Pharmacy, Inc. dba  
St Pauls Pharmacy 2 only

22  
23 In the interest of a prompt and speedy settlement of this matter, consistent with the public  
24 interest and the responsibility of the Board of Pharmacy of the Department of Consumer Affairs,  
25 the parties hereby agree to the following Stipulated Surrender and Disciplinary Order which will  
26 be submitted to the Board for approval and adoption as the final disposition of the Accusation  
27 solely with respect to Prestige Pharmacy, Inc. dba St. Pauls Pharmacy 2. It does not apply to  
28 Tramanh Nu Ton.

1 **PARTIES**

2 1. Anne Sodergren (Complainant) is the Executive Officer of the Board of Pharmacy  
3 (Board). She brought this action solely in her official capacity and is represented in this matter by  
4 Rob Bonta, Attorney General of the State of California, by Stephanie J. Lee, Deputy Attorney  
5 General.

6 2. Prestige Pharmacy, Inc., dba St. Pauls Pharmacy 2, (Respondent) is represented in  
7 this proceeding by attorney Herbert L. Weinberg, whose address is: Fenton Law Group, LLP,  
8 1990 S. Bundy Drive Suite 777, Los Angeles, CA 90025.

9 3. On or about June 14, 2010, the Board issued Pharmacy Permit No. PHY 50331 to  
10 Prestige Pharmacy, Inc., dba St. Pauls Pharmacy 2 (Respondent). From June 14, 2010 to  
11 February 12, 2019, Tramanh Nu Ton was the President, 100% shareholder, and Pharmacist-in-  
12 Charge of Prestige Pharmacy, Inc., dba St. Pauls Pharmacy 2. The Pharmacy Permit was in full  
13 force and effect at all times relevant to the charges and expired on February 12, 2019, and has not  
14 been renewed.

15 **JURISDICTION**

16 4. Accusation No. 6886 was filed before the Board, and is currently pending against  
17 Respondent. The Accusation and all other statutorily required documents were properly served  
18 on Respondent on September 29, 2020. Respondent timely filed its Notice of Defense contesting  
19 the Accusation. A copy of Accusation No. 6886 is attached as Exhibit A and incorporated by  
20 reference.

21 **ADVISEMENT AND WAIVERS**

22 5. Respondent has carefully read, fully discussed with counsel, and understands the  
23 charges and allegations in Accusation No. 6886. Respondent also has carefully read, fully  
24 discussed with counsel, and understands the effects of this Stipulated Surrender of License and  
25 Order.

26 6. Respondent is fully aware of its legal rights in this matter, including the right to a  
27 hearing on the charges and allegations in the Accusation; the right to confront and cross-examine  
28 the witnesses against them; the right to present evidence and to testify on its own behalf; the right

1 to the issuance of subpoenas to compel the attendance of witnesses and the production of  
2 documents; the right to reconsideration and court review of an adverse decision; and all other  
3 rights accorded by the California Administrative Procedure Act and other applicable laws.

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

6 **CULPABILITY**

7 8. Respondent understands that the charges and allegations in Accusation No. 6886, if  
8 proven at a hearing, constitute cause for imposing discipline upon its Pharmacy Permit.

9 9. For the purpose of resolving the Accusation without the expense and uncertainty of  
10 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual  
11 basis for the charges in the Accusation and that those charges constitute cause for discipline.  
12 Respondent hereby gives up its right to contest that cause for discipline exists based on those  
13 charges.

14 10. Respondent understands that by signing this stipulation Respondent enables the Board  
15 to issue an order accepting the surrender of its Pharmacy Permit without further process.

16 **CONTINGENCY**

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

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







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**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: 7/21/2021

Respectfully submitted,

ROB BONTA  
Attorney General of California  
ARMANDO ZAMBRANO  
Supervising Deputy Attorney General



STEPHANIE J. LEE  
Deputy Attorney General  
*Attorneys for Complainant*

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**Exhibit A**

**Accusation No. 6886**

1 XAVIER BECERRA  
Attorney General of California  
2 ARMANDO ZAMBRANO  
Supervising Deputy Attorney General  
3 STEPHANIE J. LEE  
Deputy Attorney General  
4 State Bar No. 279733  
5 300 So. Spring Street, Suite 1702  
Los Angeles, CA 90013  
6 Telephone: (213) 269-6185  
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9 **BEFORE THE**  
**BOARD OF PHARMACY**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 6886

13 **PRESTIGE PHARMACY, INC., DBA**  
14 **ST. PAULS PHARMACY 2, TRAMANH**  
15 **NU TON (PRESIDENT AND 100%**  
16 **OWNER)**  
8809 Whitter Blvd.  
Pico Rivera, CA 90660

**ACCUSATION**

17 **Pharmacy Permit License No. PHY 50331,**

18 **and**

19 **TRAMANH NU TON**  
20 12235 Beach Blvd. Ste. 104C  
21 Stanton, CA 90680

22 **Pharmacist License No. RPH 59598**

23 Respondents.

24  
25 **PARTIES**

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

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**STATUTORY PROVISIONS**

9. Section 4059 of the Code states:

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

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

11. Section 4301 of the Code states:

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

...

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

...

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

...

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

12. Section 4306.5 of the Code states:

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

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

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13. Section 4307 states, in pertinent part:

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

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

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

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

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

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

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

15. Health and Safety Code section 11162.1 states:

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

...

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

...

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

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

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

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

9 **REGULATORY PROVISIONS**

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

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

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

19 18. Federal Code of Regulations, title 21, section 1306.04 states, in pertinent  
20 part:

21 (a) A prescription for a controlled substance to be effective must be issued for a  
22 legitimate medical purpose by an individual practitioner acting in the usual course of  
23 his professional practice. The responsibility for the proper prescribing and dispensing  
24 of controlled substances is upon the prescribing practitioner, but a corresponding  
25 responsibility rests with the pharmacist who fills the prescription. An order purporting  
26 to be a prescription issued not in the usual course of professional treatment or in  
27 legitimate and authorized research is not a prescription within the meaning and intent  
28 of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a  
purported prescription, as well as the person issuing it, shall be subject to the  
penalties provided for violations of the provisions of law relating to controlled  
substances.

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

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

**DEFINITIONS**

20. Section 4022 states:

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

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

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

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

21. Section 4036.5 states:

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

22. Alprazolam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(1), and a dangerous drug pursuant to Business and Professions Code section 4022. Alprazolam is an anxiety treatment medication.

23. Hydrocodone/acetaminophen (APAP) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(I), and a dangerous drug pursuant to Business and Professions Code section 4022. Hydrocodone is a pain medication.

24. Promethazine/codeine is a Schedule V controlled substance pursuant to Health and Safety Code section 11058(c)(1), and a dangerous drug pursuant to Business and Professions Code section 4022. Promethazine/codeine is a cough treatment medication.

**COST RECOVERY**

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

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**FACTUAL ALLEGATIONS**

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

10           27. In May 2019, the Board began an investigation into Respondent St. Paul’s Pharmacy.  
11 The Board inspector reviewed CURES dispensing data reported by Respondent St. Paul’s  
12 Pharmacy for the period of May 7, 2016 through May 7, 2019. The inspector determined that  
13 while Respondent Ton was the pharmacist-in-charge, the pharmacy had filled a number of  
14 prescriptions for controlled substances during that period that appeared to exhibit multiple  
15 objective factors of irregularity—or red flags—indicating that the prescriptions were not issued  
16 for a legitimate medical purpose.

17           28. On or about June 5, 2019, the Board inspector visited Respondent St. Paul’s  
18 Pharmacy at the address of record and discovered the business was closed. Signs posted on the  
19 premises advised patients that their prescriptions could be obtained at the CVS Pharmacy No.  
20 9769 nearby. The Board inspector visited CVS Pharmacy No. 9769 and spoke with the  
21 pharmacist-in-charge, who indicated that Respondent St. Paul’s Pharmacy’s prescriptions and  
22 records had been transferred to CVS Pharmacy No. 9769.

23           29. On or about September 20, 2019, upon requests to CVS Pharmacy No. 9769, the  
24 Board inspector received Respondent St. Paul’s Pharmacy’s dispensing records and available  
25 original prescription records for the time period of May 7, 2016 through May 7, 2019. The  
26 dispensing records lacked drug cost and payment information. The Board inspector’s review of  
27 the records during this time period identified the following dispensing trends and patterns of

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1 irregularity indicating that numerous prescriptions were not issued for a legitimate medical  
2 purpose:

3 **(a) Patterns of irregularities were identifiable because of low percentages of controlled**  
4 **substance prescriptions.**

5 30. In total, the prescriptions dispensed by Respondent St. Paul's Pharmacy were largely  
6 for non-controlled substances. Low percentages of controlled substance prescriptions were  
7 dispensed by Respondent St. Paul's Pharmacy during this time period, which would cause  
8 patterns of irregularities from specific prescribers of controlled substances to stand out, especially  
9 if multiple identical or similar prescriptions were presented to the pharmacy on the same date.

10 DRUG CLASS (SCHEDULE)	11 NUMBER OF PRESCRIPTION S	PERCENT OF TOTAL DISPENSED
0	81,361	96.1
2	544	0.6
3	254	0.3
4	1,947	2.3
5	554	0.7
<b>TOTAL</b>	84,660	100.00%

16 **(b) Two particular prescribers exhibited multiple and apparent patterns of**  
17 **irregularity in their controlled substance prescriptions overall.**

18 **1) *There was minimal variety in the controlled substance prescriptions of Dr.***  
19 ***Armen Hovannisyan and Dr. Joseph Park.***

20 31. Among the most common prescribers of controlled substances dispensed by  
21 Respondent St. Paul's Pharmacy, all but two prescribers prescribed a wide variety of controlled  
22 substances. The following two prescribers each prescribed only three (3) controlled substances  
during the three-year period:

23 PRESCRIBER	CONTROLLED SUBSTANCE	NUMBER OF PRESCRIPTIONS
24 Armen Hovannisyan	Promethazine/codeine	118
	Alprazolam 2 mg	101
	Hydrocodone/APAP 10/325 mg	39
26 Joseph Harng Park	Hydrocodone/APAP 10/325 mg	60
	Promethazine/codeine	43
	Alprazolam 2 mg	41
	<b>Total</b>	402

1 32. This pattern of minimal variety in controlled substance prescriptions is commonly  
2 seen with illegitimate prescriptions. It is a pattern of irregularity for these controlled substances,  
3 which are commonly abused and have very specific treatment purposes, to be the only ones  
4 dispensed through a prescriber's prescriptions.

5 **2) Identical controlled substance prescriptions from multiple patients of the same**  
6 **two prescribers were received and dispensed on the same day.**

7 33. On numerous dates, Respondent St. Paul's Pharmacy received and dispensed identical  
8 or similar controlled substance prescriptions on the same day from multiple patients of Dr.  
9 Hovannisyan. Often, these prescriptions were assigned consecutive or nearly consecutive  
10 prescription numbers by the dispensing computer software, indicating that the pharmacy  
11 processed the prescriptions consecutively or nearly consecutively. For example, on  
12 December 23, 2016, Respondent St. Paul's Pharmacy was presented with and dispensed the  
13 following controlled substance prescriptions from Dr. Hovannisyan's patients:

DATE	RX NO.	PATIENT	CONTROLLED SUBSTANCE	QUANTITY
12/23/16	692355	E.M.	Hydrocodone/APAP	120
12/23/16	692354	J.G.	Alprazolam 2 mg	100
12/23/16	692353		Promethazine/codeine	240
12/23/16	692351	J.F.	Alprazolam 2 mg	100
12/23/16	692350		Promethazine/codeine	240
12/23/16	692356	L.A.	Hydrocodone/APAP	120
12/23/16	692348	Y.I.	Alprazolam 2 mg	100
12/23/16	692347		Promethazine/codeine	240

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34. This pattern of irregularity also occurred with Dr. Park’s prescriptions and patients on numerous dates. For example, on November 4, 2016, Respondent St. Paul’s Pharmacy was presented with and dispensed the following controlled substance prescriptions from Dr. Park’s patients:

DATE	RX NO.	PATIENT	CONTROLLED SUBSTANCE	QUANTITY
11/4/16	689999	W.D.	Hydrocodone/APAP	120
11/4/16	689994	E.P.	Alprazolam 2 mg	100
11/4/16	689993		Promethazine/codeine	240
11/4/16	689997	M.R.	Alprazolam 2 mg	100
11/4/16	689996		Promethazine/codeine	240
11/4/16	689980	Ma.R.	Alprazolam 2 mg	100
11/4/16	689979		Promethazine/codeine	240
11/4/16	689978	R.C.	Hydrocodone/APAP	120

**3) Dr. Hovannisyan and Dr. Park’s written prescriptions lacked required security features.**

35. The Board inspector also reviewed the available original prescription documents from both prescribers that had been dispensed by Respondent St. Paul’s Pharmacy during this time period. All of Dr. Hovannisyan’s written prescription documents failed to include a “California Security Prescription” watermark and a lot number—all security features that are required by law. Similarly, all of Dr. Park’s written prescription documents failed to include a “California Security Prescription” watermark and a lot number. Some of Dr. Hovannisyan and Dr. Park’s prescriptions were also not dated—another basic requirement—but nevertheless filled by Respondent St. Paul’s Pharmacy. These omitted security features alone invalidated the prescriptions and visibly indicated that the prescriptions were not written legitimately.

**4) Dr. Hovannisyan, Dr. Park, and many of their respective patients had addresses excessively far from St. Paul’s Pharmacy.**

36. Dr. Hovannisyan’s prescriptions listed an office address that was over 22 miles from St. Paul’s Pharmacy. Similarly, Dr. Park’s prescriptions listed an office address that was over 17 miles from St. Paul’s Pharmacy. Many patients of both prescribers also had addresses of record that were unusually long distances from either the prescriber’s office or St. Paul’s Pharmacy.

1 Long distances traveled by the patient to either the prescriber's office or the pharmacy are a red  
2 flag that would necessitate the pharmacy taking additional steps of verification to ensure the  
3 legitimacy of the prescriber's prescription.

4 **(c) The same two prescribers issued the majority of Alprazolam 2 mg prescriptions,  
5 which also exhibited multiple and apparent patterns of irregularity.**

6 37. Alprazolam 2 mg tablets are a commonly abused prescription medication. The  
7 strength of a 2 mg tablet is at least four times the recommended starting strength for patients not  
8 accustomed to taking this medication.

9 38. Dr. Hovannisyan and Dr. Park, the same two prescribers who exhibited multiple  
10 patterns of irregularity in their controlled substance prescriptions overall, also issued the vast  
11 majority of prescriptions for Alprazolam 2 mg dispensed by Respondent St. Paul's Pharmacy:

PRESCRIBER	QUANTITY PER PRESCRIPTION	NUMBER OF PRESCRIPTIONS
D.B.	30	1
E.M.	60	30
C.A.	90	1
A.A.	100	1
Armen Hovannisyan		101
Joseph Harnng Park		41
	<b>Total</b>	175

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18 **1) Dr. Hovannisyan and Dr. Park prescribed Alprazolam 2 mg exclusively in 100  
19 tablet quantities, the highest quantity dispensed by Respondents.**

20 39. These same two prescribers prescribed Alprazolam 2 mg only in 100 tablet quantities,  
21 with 100 tablets being the highest recorded quantity during this time period, which was indicative  
22 of another pattern of irregularity. In total, these two prescribers were responsible for 98.6% of all  
23 Alprazolam 2 mg prescriptions in a quantity over 60 tablets.

24 **2) Dr. Hovannisyan and Dr. Park prescribed Alprazolam exclusively in the  
25 highest available strength.**

26 40. These same two prescribers also prescribed Alprazolam exclusively in 2 mg, the  
27 highest available strength for this medication, even though other lower strengths of Alprazolam  
28 are available. Because inter-patient variability exists in age, weight, diagnosis, drug allergies,

1 medical histories, severity of symptoms being treated, tolerance to drugs, patient preferences  
2 regarding drug therapy plans, and other patient-related factors, it is a pattern of irregularity for  
3 these prescribers to uniformly prescribe Alprazolam at the highest strength to all their patients.

4 41. Of the total 105 patients who had Dr. Hovannisyanyan's prescriptions dispensed by  
5 Respondent St. Paul's Pharmacy, 55 patients were prescribed Alprazolam 2 mg. According to  
6 CURES patient data, which was accessible to Respondents, many of these 55 patients had no  
7 prior history of taking Alprazolam in an amount or for a period of time that would justify the  
8 prescription issued for the highest available strength.

9 42. Of the total 53 patients who had Dr. Park's prescriptions dispensed by Respondent St.  
10 Paul's Pharmacy, 26 patients were prescribed Alprazolam 2 mg. According to CURES patient  
11 data, which was accessible to Respondents, many of these 26 patients also had no prior history of  
12 taking Alprazolam in an amount or for a period of time that would justify the prescription issued  
13 for the highest available strength.

14 **3) Respondents concurrently dispensed Alprazolam 2 mg and**  
15 **Promethazine/Codeine to multiple patients of Dr. Hovannisyanyan and Dr. Park,**  
**despite the potential for serious drug interaction.**

16 43. In at least 67 instances, the 55 patients who were prescribed Alprazolam 2 mg by Dr.  
17 Hovannisyanyan also received concurrent prescriptions for another interacting drug, specifically  
18 Promethazine/Codeine, which is another commonly abused controlled substance. In each of these  
19 instances, Respondents concurrently dispensed both Alprazolam 2 mg and Promethazine/Codeine  
20 to the same patient, despite the potential for serious drug interaction. There was no  
21 documentation in Respondents' available dispensing or prescription records to indicate that  
22 Respondents inquired about or validated this pattern of irregularity.

23 44. In at least 33 instances, nearly all of the 26 patients who were prescribed Alprazolam  
24 2 mg by Dr. Park also received concurrent prescriptions for another interacting drug, specifically  
25 Promethazine/Codeine. In each of these instances, Respondents concurrently dispensed both  
26 Alprazolam 2 mg and Promethazine/Codeine to the same patient, despite the potential for serious  
27 drug interaction. There was no documentation in Respondents' available dispensing or

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1 prescription records to indicate that Respondents inquired about or validated this pattern of  
2 irregularity.

3 **FIRST CAUSE FOR DISCIPLINE**

4 **(Failure to Exercise or Implement Corresponding Responsibility)**

5 45. Respondent St. Paul's Pharmacy and Respondent Ton are subject to disciplinary  
6 action under sections 4301, subdivisions (d), (j), and (o); 4306.5, subdivision (b); and 4113,  
7 subdivision (c); in conjunction with Health and Safety Code section 11153, subdivision (a);  
8 California Code of Regulations, title 16, section 1761; and Federal Code of Regulations, title 21,  
9 section 1306.04, in that Respondents failed to exercise or implement their best professional  
10 judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled  
11 substances or dangerous drugs, or with regard to the provision of services. Complainant refers to,  
12 and by this reference incorporates, the allegations set forth in above paragraphs 26 through 44, as  
13 though set forth in full herein.

14 **SECOND CAUSE FOR DISCIPLINE**

15 **(Filling or Dispensing Improper Prescriptions for Controlled Substances)**

16 46. Respondent St. Paul's Pharmacy and Respondent Ton are subject to disciplinary  
17 action under sections 4301, subdivisions (d), (j), and (o); 4306.5, subdivision (b); and 4113,  
18 subdivision (c); in conjunction with Health and Safety Code sections 11162.1, subdivisions (a)  
19 and (b), and 11164; California Code of Regulations, title 16, section 1761; and Federal Code of  
20 Regulations, title 21, section 1306.05; in that Respondents filled or dispensed controlled  
21 substance prescriptions that did not comply with the form requirements of Health and Safety  
22 Code section 11162.1, or contained any significant error, omission, irregularity, uncertainty,  
23 ambiguity or alteration. Complainant refers to, and by this reference incorporates, the allegations  
24 set forth in above paragraphs 26 through 44, as though set forth in full herein.

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1 **DISCIPLINE CONSIDERATIONS**

2 47. To determine the degree of discipline, if any, to be imposed on Respondents,  
3 Complainant alleges the following:

4 a. On or about March 10, 2015, the Board issued a final Citation No. CI 2011-49360  
5 against Respondent St. Paul's Pharmacy for violating Code section 4067 [dispensing dangerous  
6 drugs on the internet without prescription issued pursuant to good faith examination] and  
7 California Code of Regulations, title 16, section 1707.5 [mailing prescriptions to patient with  
8 non-conforming prescription labels]. A total \$20,000 fine was issued pursuant to the final  
9 Citation. The basis for the citation was that on or about January 10, 2011, Respondent St. Paul's  
10 Pharmacy engaged in providing dangerous drugs for delivery in partnership with the Alliance  
11 Health Group, and had confirmed 5,240 prescriptions, of which 148 were confirmed as being  
12 mailed to California residents. The basis for the citation was also that on or about September 27,  
13 2012, during a Board inspection at Respondent St. Paul's Pharmacy, the pharmacy engaged in  
14 mailing prescriptions within California with prescription labels that did not conform to state  
15 labeling requirements.

16 b. On or about March 10, 2015, the Board issued a final Citation No. CI 2013-59714  
17 against Respondent Ton for violating Code section 4067 [dispensing dangerous drugs on the  
18 internet without prescription issued pursuant to good faith examination] and California Code of  
19 Regulations, title 16, section 1707.5 [mailing prescriptions to patient with non-conforming  
20 prescription labels]. A total \$20,000 fine was issued pursuant to the final Citation. The bases for  
21 the citation were the same as those for Citation No. CI 2011-49360, alleged above in paragraph  
22 47(a), and Respondent Ton was the pharmacist-in-charge at the time of these incidents.

23 **OTHER MATTERS**

24 48. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number  
25 PHY 50331 issued to Respondent St. Paul's Pharmacy, Respondent St. Paul's Pharmacy shall be  
26 prohibited from serving as a manager, administrator, owner, member, officer, director, associate,  
27 or partner of a licensee for five years if Pharmacy Permit Number PHY 50331 is placed on  
28 probation or until Pharmacy Permit Number PHY 50331 is reinstated if it is revoked.



1           5.     Ordering Prestige Pharmacy, Inc., dba St. Pauls Pharmacy 2 and Tramanh Nu Ton to  
2 pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case,  
3 pursuant to Business and Professions Code section 125.3; and,

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

5

6     DATED: 9/19/2020

*Anne Sodergren*

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

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