

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

**In the Matter of the Petition for Early Termination of  
Probation of:**

**PARISA KHANI, Petitioner**

**Agency Case Nos. 7005 and 7075**

**OAH No. 2025090152**

**DECISION**

A quorum of the Board of Pharmacy (Board) heard this matter on September 11, 2025, via videoconference. Administrative Law Judge Sean Gavin of the Office of Administrative Hearings presided from Sacramento, California.

Kristina T. Jarvis, Deputy Attorney General, represented the Attorney General under Government Code section 11522.

Petitioner Parisa Khani appeared without an attorney.

Evidence was received, the record closed, and the matter was submitted for decision on September 11, 2025.

## **FACTUAL FINDINGS**

### **License and Disciplinary History**

1. On April 25, 2003, the Board issued petitioner Pharmacist License Number RPH 54486. The license is active and will expire on March 31, 2027, unless renewed.

2. In January 2021, the Board's Executive Officer (complainant) filed an Accusation in Board Case Number 7005 against Century Pico Pharmacy Inc. (Century Pico Pharmacy) and several pharmacists who worked there, including petitioner. Generally, complainant alleged that between February 2017 and March 2020, Century Pico Pharmacy dispensed at least 422 controlled substance prescriptions (over 37,000 tablets) from prescribers with patterns of irregularities and red flags for potential abuse without ensuring the prescriptions were issued for legitimate medical purposes in the usual course of professional practice. Regarding petitioner, complainant alleged she personally approved dispensing six controlled substance prescriptions for 540 tablets of oxycodone 30 milligrams (mg) which had irregularities and red flags of illegitimacy. Based on those allegations, complainant sought to discipline petitioner's license for unprofessional conduct consisting of her failure to exercise corresponding responsibility.

3. In September 2021, complainant filed an Accusation in Board Case Number 7075 against Century Pharmacy and several pharmacists who worked there, including petitioner. Generally, complainant alleged Century Pharmacy and its pharmacists violated several provisions of the Pharmacy Law and its associated regulations. Regarding petitioner, complainant alleged that between April 2017 and April 2020, she dispensed "at least 65 controlled substance prescriptions (and 7,0565.5

[sic] units of controlled substances) in the presence of multiple factors of irregularity or red flags, evidencing that they were not written for legitimate medical purposes.” The red flags included:

- Many prescriptions were for highly abused controlled substances.
- Patients paid with cash for controlled substances.
- Prescribers’ profiles were incongruent with their self-reported areas of practice on the Board’s online database, and their prescribing patterns were unusually limited, with a small number of commonly abused controlled substances accounting for a large percentage of the total prescriptions.
- The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to all patients receiving the medication without regard for interpatient variability. Most of the prescriptions listed identical quantities and directions for use.
- Multiple patients were diagnosed with similar or identical ailments by the same prescriber.
- Patients traveled excessive distances between the medical offices of various prescribers and the pharmacy.
- Patients presented to the pharmacy with prescriptions for identical controlled substances, strengths and directions for use. These prescriptions were assigned consecutive or nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.

- Prescriptions for controlled substances were written on prescription documents lacking multiple security features and failing to comply with Health and Safety Code section 11162.1.
- Petitioner dispensed at least 35 controlled substance prescriptions (and 3,330 tablets) written on non-compliant prescription documents.
- Many patients who had not filled an opioid prescription for over two months presented with prescriptions for the highest strength oxycodone, 30 mg, at total daily doses of between three and five times the recommended safe dose.
- Although supporting documentation indicated the Controlled Substance Utilization, Review and Evaluation System (CURES) was checked to inquire about the controlled substance dispensing histories of various patients, petitioner either inappropriately scrutinized or simply ignored the information and dispensed 17 prescriptions to opioid naive patients.

4. Based on those allegations, complainant sought to discipline petitioner's license for dispensing controlled substances with variations from prescriptions, unprofessional conduct consisting of her failure to exercise corresponding responsibility to verify prescriptions, and dispensing controlled substance prescriptions written on prescription documents lacking multiple required security features.

5. Effective April 28, 2023, petitioner entered into a Stipulated Settlement and Disciplinary Order with the Board pursuant to which she admitted complainant could establish a factual basis for the charges in both Accusations and that those charges constituted cause for discipline. Based thereon, the Board revoked petitioner's

license, immediately stayed the revocation, and placed the license on probation for three years subject to probationary terms and conditions.

## **Petition and Evidence at Hearing**

6. On May 5, 2025, petitioner signed her Petition for Early Termination of Probation (Petition) and submitted it to the Board. Through her Petition and testimony, she explained she seeks to end her probation early because she has accepted responsibility for her past mistakes and changed her practices to become a safer pharmacist. She also noted that because her Board probation limits her employment opportunities, she must work far from her home, which restricts the time she can spend with her family. Moreover, she finds being on probation “personally humiliating” and believes it has “unfairly tarnished [her] reputation among colleagues, potential employers, and prospective patients.”

7. With her Petition, petitioner submitted a written statement in which she summarized her work to comply with probation and noted she has “taken several steps beyond what is required.” Specifically, she has completed “over 30 hours of Continuing Education (CE), exceeding the required amount.” Additionally, she has studied materials from the Pharmacy Technician Certification Exam, American Journal of Managed Care, and the Journal of the American Pharmacists Association. She also completed a cultural competency course and attended a virtual lecture on drug abuse in June 2023. Those efforts “broadened [her] understanding of pharmacists’ responsibilities related to controlled substances.” Finally, she regularly reviews professional journals to stay informed about clinical and pharmaceutical innovations and routinely visits the Board’s website “to remain updated on legal changes, enforcement actions, and industry news.”

8. Petitioner previously worked for Century Pharmacy for approximately three years but worked at Century Pico Pharmacy for only one month. Before the Accusations, she was not aware of the "opioid epidemic." She had heard of corresponding responsibility for pharmacists, but she has learned much more about it through her probationary coursework. Now, she understands her corresponding responsibility requires her to ensure a prescription is legitimate by checking that it has a proper number or barcode and diagnosis code. She also verifies the prescriber is a pain management doctor whose information is current and accurate, the patient and doctor are close to the pharmacy, and the dose does not begin at the maximum level.

9. Petitioner currently works as a part-time staff pharmacist. When her probation ends, she intends to continue working as a staff pharmacist in independent pharmacies, but she would look for work closer to her home. In her current position, she is more comfortable checking CURES, looking for red flags, and questioning prescribers than she was in the past. In the last six months, she has rejected two or three prescriptions based on red flags. In one instance, she convinced the prescriber to modify the prescription to a lower dose of Norco or a weaker drug. Another doctor declined to do so and sent the patient to a different pharmacy.

10. In support of her petition, petitioner submitted her certificates of continuing education. She also submitted letters of support from two pharmacists-in-charge (PIC) with whom she worked. The first PIC, Ash Soliman, Pharm.D., believes petitioner is "a highly qualified, professional, and ethical pharmacist." Dr. Soliman praised petitioner's "strong clinical knowledge, familiarity with pharmacy law and ethics, and dedication to patient care."

11. The second PIC, Seyha Kem, observed petitioner "brings a high level of dedication to her role and always goes the extra mile to ensure that patients are

educated about their medications and treatment plans.” He also praised her “calm demeanor and sound clinical judgment.”

12. Additionally, petitioner submitted letters of support from two rabbis. The first, David Shofet, noted that petitioner exemplifies the synagogue’s values of integrity, compassion, and community service. He has observed community members speak highly of petitioner’s “respectful demeanor, attention to detail, and willingness to go above and beyond to ensure patients receive the information and care they need.”

13. The second rabbi, Daniel Illulian, has observed petitioner for 10 years “not only in her professional capacity but also as a respected and active member of our community.” He believes she has “consistently demonstrated integrity, humility, and a sincere commitment to the well-being of others.” He noted that “[m]embers of our community frequently express their confidence in her advice and service, knowing they can rely on her to act in their best interest and in accordance with all applicable laws and ethical standards.”

## **Analysis**

14. Petitioner’s misconduct that led to her license discipline endangered the public and fell short of the Board’s expectation of its licensees. Through her Petition and testimony, petitioner demonstrated a lack of insight into the specific reasons for her license discipline. Although she professed to have learned from her mistakes, at hearing, her understanding of corresponding responsibility was superficial. Her license discipline involved missing or ignoring several red flags. Although she has the support of her PICs, she did not persuasively demonstrate sufficient rehabilitation from her severe misconduct. Beyond a cursory explanation of corresponding responsibility, she

did not convincingly explain what specific steps she must take to avoid similar problems if she were to practice without additional oversight and supervision. Finally, she did not provide any compelling need to terminate her probation early.

15. In light of the severity of petitioner's misconduct, she and the Board agreed to a three-year probation term. The Board required probation not to punish petitioner, but to protect public safety by monitoring her and ensuring she can safely practice. (Bus. & Prof. Code, § 4001.1; *Cornell v. Reilly* (1954) 127 Cal.App.2d 178, 184.) She has served approximately two and a half years of her probation and had the burden to prove her probation should end early. For the reasons stated above, she did not meet her burden. Therefore, her petition should be denied.

## **LEGAL CONCLUSIONS**

1. A Board licensee whose license has been placed on probation for three years may petition the Board for reinstatement after two years. (Bus. & Prof. Code, § 4309, subd. (a)(2).) Petitioner filed her petition in May 2025, more than two years after her probation began. Her Petition is therefore timely.

2. Petitioner bears the burden of proving her rehabilitation. (*Housman v. Bd. of Medical Examiners* (1948) 84 Cal.App.2d 308.) The standard of proof is clear and convincing evidence to a reasonable certainty. (*Hippard v. State Bar* (1989) 49 Cal.3d 1084; *Feinstein v. State Bar* (1952) 39 Cal.2d 541.)

3. When deciding a petition, the Board may consider petitioner's activities while the license was in good standing and after the disciplinary action was taken, the offense for which petitioner was disciplined, petitioner's documented rehabilitative

efforts, and petitioner's general reputation for truth and professional ability. (Bus. & Prof. Code, § 4309, subd. (d)(1)-(5).)

4. As discussed above, petitioner did not produce clear and convincing rehabilitation evidence to show her probation should end early. Therefore, her Petition should be denied.

### **ORDER**

On September 11, 2025, the Board of Pharmacy, Department of Consumer Affairs, adopted the attached Decision as its own.

The Petition for Early Termination of Probation filed by Parisa Khani is DENIED.

This Decision shall become effective at 5:00 p.m. on December 4, 2025.

It is so ORDERED on November 4, 2025.

BOARD OF PHARMACY  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

By



Seung W. Oh, Pharm.D.  
Board President

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

**In the Matter of the Accusation Against:**

**CENTURY PHARMACY, INC., DBA, CENTURY PHARMACY,  
JOSEPH AMIN,  
Pharmacy Permit No. PHY 34252;**

**MORRIS GHADISHAH  
Pharmacist License No. RPH 70585;**

**JILA MOHAMMADI,  
Pharmacist License No. RPH 70372;**

**SHIVA KIAEE FARZAN,  
Pharmacist License No. RPH 44807;**

**MEHRDAD AHDOOT,  
Pharmacist License No. RPH 43292;**

**SHIRIN AZIZZADEH,  
Pharmacist License No. RPH 53320;**

**YOUNG SOOK CHOI,  
Pharmacist License No. RPH 41950;**

**HENGAMEH SHAKERANEH,  
Pharmacist License No. RPH 45821;**

**PARISA KHANI,  
Pharmacist License No. RPH 54486;**

**SHIRIN HAROONPOOR,  
Pharmacist License No. RPH 76314;**

**and**

**MAHSHID PAYA KHALIFIAN,  
Pharmacist License No. RPH 44675,**

**Respondents.**

**Agency Case No. 7075; OAH No. 2022020695**

**and**

**In the Matter of the Accusation Against:**

**CENTURY PICO PHARMACY, INC., DBA, CENTURY PICO  
PHARMACY INC., JOSEPH AMIN, BAHRAM SAMOUHA  
Pharmacy Permit No. PHY 41037;**

**HASTI ASHLYN ELAHI  
Pharmacist License No. RPH 79647;**

**SHIRIN AZIZZADEH,  
Pharmacist License No. RPH 53320;**

**BAHRAM SAMOUHA,  
Pharmacist License No. RPH 45531;**

**and**

**PARISA KHANI,  
Pharmacist License No. RPH 54486,**

**Respondents.**

**Agency Case No. 7005; OAH No. 2022020695**


**DECISION AND ORDER**

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

This Decision shall become effective at 5:00 p.m. on April 28, 2023.

It is so ORDERED on March 29, 2023.

BOARD OF PHARMACY  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

By   
Seung W. Oh, Pharm.D.  
Board President

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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:

Case No. 7075

13 **JOSEPH AMIN DBA CENTURY**  
14 **PHARMACY**  
15 **11870 Santa Monica Blvd, Ste 108**  
**Los Angeles, CA 90025-2276**

Case No. 7005

OAH No. 2022020695

16 **Permit No. PHY 34252,**

**STIPULATED SETTLEMENT AND**  
**DISCIPLINARY ORDER REGARDING**  
**PARISA KHANI ONLY**

17 **MORRIS GHADISHAH**  
18 **227 1/2 S. Tower Dr.**  
**Beverly Hills, CA 90211c**

19 **Pharmacist License No. RPH 70585,**

20 **JILA MOHAMMADI**  
21 **11870 Santa Monica Blvd, Ste 108**  
**Los Angeles, CA 90025-2276**

22 **Pharmacist License No. RPH 70372,**

23 **SHIVA KIAEE FARZAN**  
24 **18814 Canasta Street**  
**Tarzana, CA 91356**

25 **Pharmacist License No. RPH 44807,**

26 **MEHDAD AHDOOT**  
27 **9196 Crocus Avenue**  
**Fountain Valley, CA 92708**

28 **Pharmacist License No. RPH 43292,**

1 **SHIRIN AZIZZADEH**  
2 **530 Evelyn Pl**  
3 **Beverly Hills, CA 90210**

4 **Pharmacist License No. RPH 53320,**

5 **YOUNG SOOK CHOI**  
6 **500 S. Lake Street, #301**  
7 **Los Angeles, CA 90057**

8 **Pharmacist License No. RPH 41950,**

9 **HENGAMEH SHAKERANEH**  
10 **2035 Greenfield Avenue**  
11 **Los Angeles, CA 90025**

12 **Pharmacist License No. RPH 45821,**

13 **PARISA KHANI**  
14 **P.O. Box 10625**  
15 **Beverly Hills, CA 90209**

16 **Pharmacist License No. RPH 54486,**

17 **SHIRIN HAROONPOOR**  
18 **10307 Missouri Avenue, #201**  
19 **Los Angeles, CA 90025**

20 **Pharmacist License No. RPH 76314,**

21 **and**

22 **MAHSHID PAYA KHALIFIAN**  
23 **10362 Summer Holly Circle**  
24 **Los Angeles, CA 90077**

25 **Pharmacist License No. RPH 44675**

26 Respondents.

27 In the Matter of the Accusation Against:

28 **CENTURY PICO PHARMACY INC. DBA**  
**CENTURY PICO PHARMACY INC.,**  
**JOSEPH AMIN, BAHRAM SAMOUHA**  
**8722 Pico Blvd**  
**Los Angeles, CA 90035**

**Permit No. PHY 41037,**

**HASTI ASHLYN ELAHI**  
**313 W. California Ave, #306**  
**Glendale, CA 91203**

**Pharmacist License No. RPH 79647,**

1 **SHIRIN AZIZADEH**  
2 **530 Evelyn Pl**  
3 **Beverly Hills, CA 90210**

4 **Pharmacist License No. RPH 53320,**

5 **BAHRAM SAMOUHA**  
6 **311 N. Palm Dr.**  
7 **Beverly Hills, CA 90210**

8 **Pharmacist License No. RPH 45531**

9 **And**

10 **PARISA KHANI**  
11 **P.O. BOX 16025,**  
12 **Beverly Hills, CA 90209**

13 **Pharmacist License No. RPH 54486**

14 Respondents.

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

17 **PARTIES**

18 1. Anne Sodergren (Complainant) is the Executive Officer of the Board of Pharmacy  
19 (Board). She brought this action solely in her official capacity and is represented in this matter by  
20 Rob Bonta, Attorney General of the State of California, by Kevin J. Rigley, Deputy Attorney  
21 General.

22 2. Respondent Parisa Khani (Respondent) is represented in this proceeding by attorney  
23 Robert D. Cucher, Esq., 9454 Wilshire Blvd, Ste 600, Beverly Hills, CA 90212-2980.

24 3. On or about April 25, 2003, the Board issued Pharmacist License Number RPH  
25 54486 to Parisa Khani (Respondent). The Pharmacist License was in full force and effect at all  
26 times relevant to the charges brought herein and will expire on March 31, 2023, unless renewed.

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1 **JURISDICTION**

2 4. Accusation No. 7075 and Accusation No. 7005 were filed before the Board, and are  
3 currently pending against Respondent in a consolidated proceeding. Accusation No. 7075 and  
4 Accusation No. 7005 and all other statutorily required documents were properly served on  
5 Respondent on September 21, 2021, and January 22, 2021, respectively. Respondent timely filed  
6 her Notices of Defense contesting Accusation No. 7075 and Accusation No. 7005.

7 5. A copy of Accusation No. 7075 is attached as exhibit A and Accusation No. 7005 as  
8 exhibit B and incorporated herein by reference.

9 **ADVISEMENT AND WAIVERS**

10 6. Respondent has carefully read, fully discussed with counsel, and understands the  
11 charges and allegations in Accusation No. 7075 and Accusation No. 7005 (these consolidated  
12 accusations are referred to herein together as “the Accusation” or “this matter”). Respondent has  
13 also carefully read, fully discussed with counsel, and understands the effects of this Stipulated  
14 Settlement and Disciplinary Order.

15 7. Respondent is fully aware of her legal rights in this matter, including the right to a  
16 hearing on the charges and allegations in the Accusation; the right to confront and cross-examine  
17 the witnesses against her; the right to present evidence and to testify on her own behalf; the right  
18 to the issuance of subpoenas to compel the attendance of witnesses and the production of  
19 documents; the right to reconsideration and court review of an adverse decision; and all other  
20 rights accorded by the California Administrative Procedure Act and other applicable laws.

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

23 **CULPABILITY**

24 9. Respondent understands and agrees that the charges and allegations in Accusation  
25 No. 7075 and Accusation No. 7005, if proven at a hearing, constitute cause for imposing  
26 discipline upon her Pharmacist License.

27 10. For the purpose of resolving the Accusation without the expense and uncertainty of  
28 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual

1 basis for the charges in the Accusation, and that Respondent hereby gives up her right to contest  
2 those charges.

3 11. Respondent agrees that her Pharmacist License is subject to discipline and she agrees  
4 to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

5 **CONTINGENCY**

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

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

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

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

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1 **DISCIPLINARY ORDER**

2 IT IS HEREBY ORDERED that Pharmacist License No. RPH 54486 issued to Respondent  
3 Parisa Khani is revoked. However, the revocation is stayed and Respondent is placed on probation  
4 for three (3) years on the following terms and conditions:

5 1. **Obey All Laws**

6 Respondent shall obey all state and federal laws and regulations.

7 Respondent shall report any of the following occurrences to the Board, in writing, within  
8 seventy- two (72) hours of such occurrence:

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

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

21 2. **Report to the Board**

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

26 Failure to submit timely reports in a form as directed shall be considered a violation of  
27 probation. Any period(s) of delinquency in submission of reports as directed may be added to the  
28 total period of probation. Moreover, if the final probation report is not made as directed,

1 probation shall be automatically extended until such time as the final report is made and accepted  
2 by the Board.

3 **3. Interview with the Board**

4 Upon receipt of reasonable prior notice, Respondent shall appear in person for interviews  
5 with the Board or its designee, at such intervals and locations as are determined by the Board or  
6 its designee. Failure to appear for any scheduled interview without prior notification to Board  
7 staff, or failure to appear for two (2) or more scheduled interviews with the Board or its designee  
8 during the period of probation, shall be considered a violation of probation.

9 **4. Cooperate with Board Staff**

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

16 **5. Continuing Education**

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

19 **6. Reporting of Employment and Notice to Employers**

20 During the period of probation, Respondent shall notify all present and prospective  
21 employers of the decision in case number 7075 and the terms, conditions and restrictions imposed  
22 on Respondent by the decision, as follows:

23 Within thirty (30) days of the effective date of this decision, and within ten (10) days of  
24 undertaking any new employment, Respondent shall report to the Board in writing the name,  
25 physical address, and mailing address of each of her employer(s), and the name(s) and telephone  
26 number(s) of all of her direct supervisor(s), as well as any pharmacist(s)-in-charge, designated  
27 representative(s)-in-charge, responsible manager, or other compliance supervisor(s) and the work  
28 schedule, if known. Respondent shall also include the reason(s) for leaving the prior

1 employment. Respondent shall sign and return to the Board a written consent authorizing the  
2 Board or its designee to communicate with all of Respondent's employer(s) and supervisor(s),  
3 and authorizing those employer(s) or supervisor(s) to communicate with the Board or its  
4 designee, concerning Respondent's work status, performance, and monitoring. Failure to comply  
5 with the requirements or deadlines of this condition shall be considered a violation of probation.

6       Within thirty (30) days of the effective date of this decision, and within fifteen (15) days of  
7 Respondent undertaking any new employment, Respondent shall cause (a) her direct supervisor,  
8 (b) her pharmacist-in-charge, designated representative-in-charge, responsible manager, or other  
9 compliance supervisor, and (c) the owner or owner representative of her employer, to report to the  
10 Board in writing acknowledging that the listed individual(s) has/have read the decision in case  
11 number 7075, and terms and conditions imposed thereby. If one person serves in more than one  
12 role described in (a), (b), or (c), the acknowledgment shall so state. It shall be the Respondent's  
13 responsibility to ensure that these acknowledgment(s) are timely submitted to the Board. In the  
14 event of a change in the person(s) serving the role(s) described in (a), (b), or (c) during the term  
15 of probation, Respondent shall cause the person(s) taking over the role(s) to report to the Board in  
16 writing within fifteen (15) days of the change acknowledging that he or she has read the decision  
17 in case number 7075, and the terms and conditions imposed thereby.

18       If Respondent works for or is employed by or through an employment service, Respondent  
19 must notify the person(s) described in (a), (b), and (c) above at every entity licensed by the Board  
20 of the decision in case number 7075, and the terms and conditions imposed thereby in advance of  
21 Respondent commencing work at such licensed entity. A record of this notification must be  
22 provided to the Board upon request.

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

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

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

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

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

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

13 **8. Restrictions on Supervision and Oversight of Licensed Facilities**

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

18 **9. Reimbursement of Board Costs**

19 As a condition precedent to successful completion of probation, Respondent shall pay to the  
20 Board its costs of investigation and prosecution in the amount of \$4,000. Respondent shall make  
21 said payments as follows:

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

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

28 ///

1           **10. Probation Monitoring Costs**

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

6           **11. Status of License**

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

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

15           **12. License Surrender While on Probation/Suspension**

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

24           Upon acceptance of the surrender, Respondent shall relinquish her pocket and/or wall  
25 license, including any indicia of licensure not previously provided to the Board within ten (10)  
26 days of notification by the Board that the surrender is accepted if not already provided.  
27 Respondent may not reapply for any license from the Board for three (3) years from the effective  
28 date of the surrender. Respondent shall meet all requirements applicable to the license sought as

1 of the date the application for that license is submitted to the Board, including any outstanding  
2 costs.

3 **13. Practice Requirement – Extension of Probation**

4 Except during periods of suspension, Respondent shall, at all times while on probation, be  
5 employed as a pharmacist in California for a minimum of 80 hours per calendar month. Any  
6 month during which this minimum is not met shall extend the period of probation by one month.  
7 During any such period of insufficient employment, Respondent must nonetheless comply with  
8 all terms and conditions of probation, unless Respondent receives a waiver in writing from the  
9 Board or its designee.

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

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

23 **14. Violation of Probation**

24 If Respondent has not complied with any term or condition of probation, the Board shall  
25 have continuing jurisdiction over Respondent, and the Board shall provide notice to Respondent  
26 that probation shall automatically be extended, until all terms and conditions have been satisfied  
27 or the Board has taken other action as deemed appropriate to treat the failure to comply as a  
28

1 violation of probation, to terminate probation, and to impose the penalty that was stayed. The  
2 Board or its designee may post a notice of the extended probation period on its website.

3 If Respondent violates probation in any respect, the Board, after giving Respondent notice  
4 and an opportunity to be heard, may revoke probation and carry out the disciplinary order that  
5 was stayed. If a petition to revoke probation or an accusation is filed against Respondent during  
6 probation, or the preparation of an accusation or petition to revoke probation is requested from  
7 the Office of the Attorney General, the Board shall have continuing jurisdiction and the period of  
8 probation shall be automatically extended until the petition to revoke probation or accusation is  
9 heard and decided, and the charges and allegations in the Accusation shall be deemed true and  
10 correct.

11 **15. Completion of Probation**

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

14 **16. Ethics Course**

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

23 **17. No Ownership or Management of Licensed Premises**

24 Respondent shall not own, have any legal or beneficial interest in, nor serve as a manager,  
25 administrator, member, officer, director, trustee, associate, or partner of any business, firm,  
26 partnership, or corporation currently or hereinafter licensed by the Board for a period of five (5)  
27 years from the effective date of the Decision and Order. Respondent shall sell or transfer any  
28 legal or beneficial interest in any entity licensed by the Board within ninety (90) days following

1 the effective date of this decision and shall immediately thereafter provide written proof thereof  
2 to the Board. Failure to timely divest any legal or beneficial interest(s) or provide documentation  
3 thereof shall be considered a violation of probation.

4 **18. Board's One-Day Training Program**

5 Within the first year of probation, Respondent shall enroll in the Board's one-day, six (6)  
6 hour, training program, "Preventing Prescription Drug Abuse and Drug Diversion," at  
7 Respondent's expense. Respondent shall provide proof of enrollment upon request. Within thirty  
8 (30) days of completion, Respondent shall submit a copy of the certificate of completion to the  
9 Board or its designee. Failure to timely enroll in the training program, to initiate the training  
10 program during the first year of probation, to successfully complete it before the end of the  
11 second year of probation, or to timely submit proof of completion to the Board or its designee,  
12 shall be considered a violation of probation.

13 **ACCEPTANCE**

14 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully  
15 discussed it with my attorney, Robert D. Cucher. I understand the stipulation and the effect it will  
16 have on my Pharmacist License. I enter into this Stipulated Settlement and Disciplinary Order  
17 voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the  
18 Board of Pharmacy.

19  
20 DATED: \_\_\_\_\_  
21 *PARISA KHANI*  
*Respondent*

22  
23 I have read and fully discussed with Respondent Parisa Khani the terms and conditions and  
24 other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its  
25 form and content.

26 DATED: \_\_\_\_\_  
27 *ROBERT D. CUCHER*  
*Attorney for Respondent*

1 the effective date of this decision and shall immediately thereafter provide written proof thereof  
2 to the Board. Failure to timely divest any legal or beneficial interest(s) or provide documentation  
3 thereof shall be considered a violation of probation.

4 **18. Board's One-Day Training Program**

5 Within the first year of probation, Respondent shall enroll in the Board's one-day, six (6)  
6 hour, training program, "Preventing Prescription Drug Abuse and Drug Diversion," at  
7 Respondent's expense. Respondent shall provide proof of enrollment upon request. Within thirty  
8 (30) days of completion, Respondent shall submit a copy of the certificate of completion to the  
9 Board or its designee. Failure to timely enroll in the training program, to initiate the training  
10 program during the first year of probation, to successfully complete it before the end of the  
11 second year of probation, or to timely submit proof of completion to the Board or its designee,  
12 shall be considered a violation of probation.

13 **ACCEPTANCE**

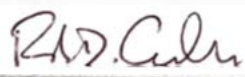
14 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully  
15 discussed it with my attorney, Robert D. Cucher. I understand the stipulation and the effect it will  
16 have on my Pharmacist License. I enter into this Stipulated Settlement and Disciplinary Order  
17 voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the  
18 Board of Pharmacy.

19  
20 DATED: 2/24/23

  
\_\_\_\_\_  
21 PARISA KHANI  
22 Respondent

23 I have read and fully discussed with Respondent Parisa Khani the terms and conditions and  
24 other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its  
25 form and content.

26 DATED: 2/24/23

  
\_\_\_\_\_  
27 ROBERT D. CUCHER  
28 Attorney for Respondent

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**ENDORSEMENT**

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

DATED: February 23, 2023

Respectfully submitted,

ROB BONTA  
Attorney General of California  
NANCY A. KAISER  
Supervising Deputy Attorney General

  
KEVIN J. RIGLEY  
Deputy Attorney General  
*Attorneys for Complainant*

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KHANI-StipSett.docx

**Exhibit A**

**Accusation No. 7075**

1 ROB BONTA  
Attorney General of California  
2 SHAWN P. COOK  
Supervising Deputy Attorney General  
3 KEVIN J. RIGLEY  
Deputy Attorney General  
4 State Bar No. 131800  
300 So. Spring Street, Suite 1702  
5 Los Angeles, CA 90013  
Telephone: (213) 269-6301  
6 Facsimile: (916) 731-2126  
*Attorneys for Complainant*  
7

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

11 In the Matter of the Accusation Against:

Case No. 7075

12 **JOSEPH AMIN,**  
**DBA CENTURY PHARMACY**  
13 11870 Santa Monica Blvd, Ste 108  
Los Angeles, CA 90025-2276  
14 Permit No. PHY 34252

**ACCUSATION**

15 and

16 **JILA MOHAMMADI**  
PO Box 5582  
17 Glendale, CA 91221  
Pharmacist License No. RPH 70372

18 and

19 **MORRIS GHADISHAH**  
20 227 ½ S. Tower Dr.  
Beverly Hills, CA 90211  
21 Pharmacist License No. RPH 70585

22 and

23 **MAHSHID PAYA KHALIFIAN**  
10362 Summer Holly Circle  
24 Los Angeles, CA 90077  
Pharmacist License No. RPH 44675

25 and

26  
27 *(Continued on next page)*  
28

1 **MEHRDAD AHDOOT**  
9196 Crocus Avenue  
2 Fountain Valley, CA 92708  
Pharmacist License No. RPH 43292

3 and

4 **SHIVA KIAEE FARZAN**  
18814 Canasta Street  
5 Tarzana, CA 91356  
6 Pharmacist License No. RPH 44807

7 and

8 **SHIRIN HAROONPOOR**  
10307 Missouri Avenue #201  
9 Los Angeles, CA 90025  
Pharmacist License No. RPH 76314

10 and

11 **YOUNG SOOK CHOI**  
12 500 S. Lake Street #301  
Los Angeles, CA 90057  
13 Pharmacist License No. RPH 41950

14 and

15 **HENGAMEH SHAKERANEH**  
16 2035 Greenfield Avenue  
Los Angeles, CA 90025  
17 Pharmacist License No. RPH 45821

18 and

19 **PARISA KHANI**  
PO Box 16025  
20 Beverly Hills, CA 90209  
Pharmacist License No. RPH 54486

21 and

22 **SHIRIN AZIZZADEH**  
530 Evelyn Place  
23 Beverly Hills, CA 90210  
24 Pharmacist License No. RPH 53320

25  
26 Respondents.

27  
28 ///

1 Complainant alleges:

2 **PARTIES**

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

5 **Joseph Amin dba Century Pharmacy**

6 2. On or about May 14, 1987, the board issued Permit Number PHY 34252 to Joseph  
7 Amin, doing business as Century Pharmacy (respondent Pharmacy). The Permit, which was in  
8 full force and effect at all times relevant to the charges brought herein, expired on May 1, 2021,  
9 and was canceled.

10 **Jila Mohammadi (Pharmacist-in-Charge from 11/16/15 to 8/26/16)**

11 3. On or about December 30, 2013, the Board issued Pharmacist License Number RPH  
12 70372 to Jila Mohammadi (respondent Mohammadi). The Pharmacist License was in full force  
13 and effect at all times relevant to the charges brought herein and will expire on January 31, 2023,  
14 unless renewed.

15 **Morris Ghadishah (Pharmacist-in-Charge from 5/1/14 to 11/1/15)**

16 4. On or about April 4, 2014, the Board issued Pharmacist License Number RPH 70585  
17 to Morris Ghadishah (respondent Ghadishah). The Pharmacist License was in full force and  
18 effect at all times relevant to the charges brought herein and will expire on March 31, 2022,  
19 unless renewed.

20 **Mahshid Paya Khalifian (Pharmacist-in-Charge from 9/1/19 to Present)**

21 5. On or about August 15, 1991, the Board issued Pharmacist License Number RPH  
22 44675 to Mashid Paya Khalifian (respondent Khalifian). The Pharmacist License was in full  
23 force and effect at all times relevant to the charges brought herein and will expire on December  
24 31, 2022, unless renewed.

25 **Mehrdad Ahdoot (Pharmacist-in-Charge from 10/5/16 to 2/4/19)**

26 6. On or about March 16, 1990, the Board issued Pharmacist License Number RPH  
27 43292 to Mehrdad Ahdoot (respondent Ahdoot). The Pharmacist License was in full force and  
28

1 effect at all times relevant to the charges brought herein and will expire on October 31, 2021,  
2 unless renewed.

3 **Shiva Kiaee Farzan (Pharmacist-in-Charge from 5/1/19 to 7/8/19)**

4 7. On or about August 27, 1991, the Board issued Pharmacist License Number RPH  
5 44807 to Shiva Farzan (respondent Farzan). The Pharmacist License was in full force and effect  
6 at all times relevant to the charges brought herein and will expire on May 31, 2023, unless  
7 renewed.

8 **Shirin Haroonpoor**

9 8. On or about March 6, 2017, the Board issued Pharmacist License Number RPH  
10 76314 to Shirin Haroonpoor (respondent Haroonpoor). The Pharmacist License, which was in  
11 full force and effect at all times relevant to the charges brought herein, will expire on March 31,  
12 2023.

13 **Young Sook Choi**

14 9. On or about August 5, 1988, the Board issued Pharmacist License Number RPH  
15 41950 to Young Sook Choi (respondent Choi). The Pharmacist License (license), which was in  
16 full force and effect at all times relevant to the charges brought herein, was canceled on July 29,  
17 2020.

18 **Hengameh Shakeraneh**

19 10. On or about October 9, 1992, the Board issued Pharmacist License Number RPH  
20 45821 to Hengameh Shakeraneh (respondent Shakeraneh). The Pharmacist License was in full  
21 force and effect at all times relevant to the charges brought herein and will expire on June 30,  
22 2022, unless renewed.

23 **Parisa Khani**

24 11. On or about April 25, 2003, the Board issued Pharmacist License Number RPH  
25 54486 to Parisa Khani (respondent Khani). The Pharmacist License was in full force and effect at  
26 all times relevant to the charges brought herein and will expire on March 31, 2023, unless  
27 renewed.

28 ///



1 suspension, or who has been a manager, administrator, owner, member, officer,  
2 director, associate, partner, or any other person with management or control of any  
3 partnership, corporation, trust, firm, or association whose application for a license has  
4 been denied or revoked, is under suspension or has been placed on probation, and  
5 while acting as the manager, administrator, owner, member, officer, director,  
6 associate, partner, or any other person with management or control had knowledge of  
7 or knowingly participated in any conduct for which the license was denied, revoked,  
8 suspended, or placed on probation, shall be prohibited from serving as a manager,  
9 administrator, owner, member, officer, director, associate, partner, or in any other  
10 position with management or control of a licensee as follows:

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

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

15 (b) “Manager, administrator, owner, member, officer, director, associate, or partner,”  
16 as used in this section and Section 4308, may refer to a pharmacist or to any other  
17 person who serves in that capacity in or for a licensee.

18 (c) The provisions of subdivision (a) may be alleged in any pleading filed pursuant to  
19 Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the  
20 Government Code. However, no order may be issued in that case except as to a  
21 person who is named in the caption, as to whom the pleading alleges the applicability  
22 of this section, and where the person has been given notice of the proceeding as  
23 required by Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of  
24 the Government Code. The authority to proceed as provided by this subdivision shall  
25 be in addition to the board’s authority to proceed under Section 4339 or any other  
26 provision of law.

### 27 **STATUTORY PROVISIONS**

28 17. Section 4073 states:

“(a) A pharmacist filling a prescription order for a drug product prescribed by its  
trade or brand name may select another drug product with the same active chemical ingredients of  
the same strength, quantity, and dosage form, and of the same generic drug name as determined  
by the United States Adopted Names (USAN) and accepted by the federal Food and Drug  
Administration (FDA), of those drug products having the same active chemical ingredients.

“(b) In no case shall a selection be made pursuant to this section if the prescriber personally  
indicates, either orally or in his or her own handwriting, “Do not substitute,” or words of similar  
meaning. Nothing in this subdivision shall prohibit a prescriber from checking a box on a  
prescription marked “Do not substitute”; provided that the prescriber personally initials the box or  
checkmark. To indicate that a selection shall not be made pursuant to this section for an electronic  
data transmission prescription as defined in subdivision (c) of Section 4040, a prescriber may

1 indicate “Do not substitute,” or words of similar meaning, in the prescription as transmitted by  
2 electronic data, or may check a box marked on the prescription “Do not substitute.” In either  
3 instance, it shall not be required that the prohibition on substitution be manually initialed by the  
4 prescriber.

5 “(c) Selection pursuant to this section is within the discretion of the pharmacist, except as  
6 provided in subdivision (b). The person who selects the drug product to be dispensed pursuant to  
7 this section shall assume the same responsibility for selecting the dispensed drug product as  
8 would be incurred in filling a prescription for a drug product prescribed by generic name. There  
9 shall be no liability on the prescriber for an act or omission by a pharmacist in selecting,  
10 preparing, or dispensing a drug product pursuant to this section. In no case shall the pharmacist  
11 select a drug product pursuant to this section unless the drug product selected costs the patient  
12 less than the prescribed drug product. Cost, as used in this subdivision, is defined to include any  
13 professional fee that may be charged by the pharmacist.

14 “(d) This section shall apply to all prescriptions, including those presented by or on behalf  
15 of persons receiving assistance from the federal government or pursuant to the California Medical  
16 Assistance Program set forth in Chapter 7 (commencing with Section 14000) of Part 3 of Division  
17 9 of the Welfare and Institutions Code.

18 “(e) When a substitution is made pursuant to this section, the use of the cost-saving drug  
19 product dispensed shall be communicated to the patient and the name of the dispensed drug  
20 product shall be indicated on the prescription label, except where the prescriber orders  
21 otherwise.”

22 18. Section 4104, states, in pertinent part:

23 “(a) Every pharmacy shall have in place procedures for taking action to protect the public  
24 when a licensed individual employed by or with the pharmacy is discovered or known to be  
25 chemically, mentally, or physically impaired to the extent it affects his or her ability to practice  
26 the profession or occupation authorized by his or her license, or is discovered or known to have  
27 engaged in the theft, diversion, or self-use of dangerous drugs.

28 ///

1           “(b) Every pharmacy shall have written policies and procedures for addressing chemical,  
2 mental, or physical impairment, as well as theft, diversion, or self-use of dangerous drugs, among  
3 licensed individuals employed by or with the pharmacy.

4           “(c) Every pharmacy shall report and provide to the board, within 14 days of the receipt or  
5 development thereof, the following information with regard to any licensed individual employed  
6 by or with the pharmacy:

7           “(1) Any admission by a licensed individual of chemical, mental, or physical impairment  
8 affecting his or her ability to practice.

9           “(2) Any admission by a licensed individual of theft, diversion, or self-use of dangerous  
10 drugs.

11           “(3) Any video or documentary evidence demonstrating chemical, mental, or physical  
12 impairment of a licensed individual to the extent it affects his or her ability to practice.

13           “(4) Any video or documentary evidence demonstrating theft, diversion, or self-use of  
14 dangerous drugs by a licensed individual.

15           “(5) Any termination based on chemical, mental, or physical impairment of a licensed  
16 individual to the extent it affects his or her ability to practice.

17           “(6) Any termination of a licensed individual based on theft, diversion, or self-use of  
18 dangerous drugs.

19           “(d) The report required in subdivision (c) shall include sufficient detail to inform the board  
20 of the facts upon which the report is based, including an estimate of the type and quantity of all  
21 dangerous drugs involved, the timeframe over which the losses are suspected, and the date of the  
22 last controlled substances inventory. Upon request of the board, the pharmacy shall prepare and  
23 submit an audit involving the dangerous drugs suspected to be missing.”

24           19. Section 4113 of the Code states:

25           “(a) Every pharmacy shall designate a pharmacist-in-charge and, within 30 days thereof,  
26 shall notify the board in writing of the identity and license number of that pharmacist and the date  
27 he or she was designated.

28       ///

1           “(b) The proposed pharmacist-in-charge shall be subject to approval by the board. The  
2 board shall not issue or renew a pharmacy license without identification of an approved  
3 pharmacist-in-charge for the pharmacy.

4           “(c) The pharmacist-in-charge shall be responsible for a pharmacy’s compliance with all  
5 state and federal laws and regulations pertaining to the practice of pharmacy.

6           “(d) Every pharmacy shall notify the board in writing, on a form designed by the board,  
7 within 30 days of the date when a pharmacist-in-charge ceases to act as the pharmacist-in-charge,  
8 and shall on the same form propose another pharmacist to take over as the pharmacist-in-charge.  
9 The proposed replacement pharmacist-in-charge shall be subject to approval by the board. If  
10 disapproved, the pharmacy shall propose another replacement within 15 days of the date of  
11 disapproval and shall continue to name proposed replacements until a pharmacist-in-charge is  
12 approved by the board.”

13           20. Section 4301 of the Code states, in pertinent part:

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

17           . . . .

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

20           . . . .

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

24           “(g) Knowingly making or signing any certificate or other document that falsely represents  
25 the existence or nonexistence of a state of facts.

26           . . . .

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

1 . . . .

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

6 21. Section 4305 of the Code states:

7 “(a) Failure by any pharmacist to notify the board in writing that he or she has ceased to act  
8 as the pharmacist-in-charge of a pharmacy, or by any pharmacy to notify the board in writing that  
9 a pharmacist-in-charge is no longer acting in that capacity, within the 30-day period specified in  
10 Sections 4101 and 4113 shall constitute grounds for disciplinary action.

11 “(b) Operation of a pharmacy for more than 30 days without supervision or management by  
12 a pharmacist-in-charge shall constitute grounds for disciplinary action.

13 “(c) Any person who has obtained a license to conduct a pharmacy, who willfully fails to  
14 timely notify the board that the pharmacist-in-charge of the pharmacy has ceased to act in that  
15 capacity, and who continues to permit the compounding or dispensing of prescriptions, or the  
16 furnishing of drugs or poisons, in his or her pharmacy, except by a pharmacist subject to the  
17 supervision and management of a responsible pharmacist-in-charge, shall be subject to summary  
18 suspension or revocation of his or her license to conduct a pharmacy.”

19 22. Section 4306.5 of the Code states:

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

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

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

1           “(c) Acts or omissions that involve, in whole or in part, the failure to consult appropriate  
2 patient, prescription, and other records pertaining to the performance of any pharmacy function.

3           “(d) Acts or omissions that involve, in whole or in part, the failure to fully maintain and  
4 retain appropriate patient-specific information pertaining to the performance of any pharmacy  
5 function.”

6           23. Health and Safety Code section 11153 states, in pertinent part:

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

17           “(b) Any person who knowingly violates this section shall be punished by imprisonment  
18 pursuant to subdivision (h) of Section 1170 of the Penal Code, or in a county jail not exceeding  
19 one year, or by a fine not exceeding twenty thousand dollars (\$20,000), or by both that fine and  
20 imprisonment.”

21           24. Health and Safety Code section 11162.1 states:

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

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

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

- 1 “(3) A chemical void protection that prevents alteration by chemical washing.
- 2 “(4) A feature printed in thermochromic ink.
- 3 “(5) An area of opaque writing so that the writing disappears if the prescription is lightened.
- 4 “(6) A description of the security features included on each prescription form.
- 5 “(7) (A) Six quantity check off boxes shall be printed on the form so that the prescriber may
- 6 indicate the quantity by checking the applicable box where the following quantities shall appear:
- 7 “1–24
- 8 “25–49
- 9 “50–74
- 10 “75–100
- 11 “101–150
- 12 “151 and over.
- 13 “(B) In conjunction with the quantity boxes, a space shall be provided to designate the units
- 14 referenced in the quantity boxes when the drug is not in tablet or capsule form.
- 15 “(8) Prescription blanks shall contain a statement printed on the bottom of the prescription
- 16 blank that the “Prescription is void if the number of drugs prescribed is not noted.”
- 17 “(9) The preprinted name, category of licensure, license number, federal controlled
- 18 substance registration number, and address of the prescribing practitioner.
- 19 “(10) Check boxes shall be printed on the form so that the prescriber may indicate the
- 20 number of refills ordered.
- 21 “(11) The date of origin of the prescription.
- 22 “(12) A check box indicating the prescriber’s order not to substitute.
- 23 “(13) An identifying number assigned to the approved security printer by the Department of
- 24 Justice.
- 25 “(14) (A) A check box by the name of each prescriber when a prescription form lists
- 26 multiple prescribers.
- 27 “(B) Each prescriber who signs the prescription form shall identify themselves as the
- 28 prescriber by checking the box by the prescriber’s name.

1           “(15) A uniquely serialized number, in a manner prescribed by the Department of Justice in  
2 accordance with Section 11162.2.

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

6           “(c) (1) A prescriber designated by a licensed health care facility, a clinic specified in  
7 Section 1200, or a clinic specified in subdivision (a) of Section 1206 that has 25 or more  
8 physicians or surgeons may order controlled substance prescription forms for use by prescribers  
9 when treating patients in that facility without the information required in paragraph (9) of  
10 subdivision (a) or paragraph (3).

11           “(2) Forms ordered pursuant to this subdivision shall have the name, category of licensure,  
12 license number, and federal controlled substance registration number of the designated prescriber  
13 and the name, address, category of licensure, and license number of the licensed health care  
14 facility the clinic specified in Section 1200, or the clinic specified in Section 1206 that has 25 or  
15 more physicians or surgeons preprinted on the form. Licensed health care facilities or clinics  
16 exempt under Section 1206 are not required to preprint the category of licensure and license  
17 number of their facility or clinic.

18           “(3) Forms ordered pursuant to this section shall not be valid prescriptions without the  
19 name, category of licensure, license number, and federal controlled substance registration number  
20 of the prescriber on the form.

21           “(4) (A) Except as provided in subparagraph (B), the designated prescriber shall maintain a  
22 record of the prescribers to whom the controlled substance prescription forms are issued, that  
23 shall include the name, category of licensure, license number, federal controlled substance  
24 registration number, and quantity of controlled substance prescription forms issued to each  
25 prescriber. The record shall be maintained in the health facility for three years.

26           “(B) Forms ordered pursuant to this subdivision that are printed by a computerized  
27 prescription generation system shall not be subject to subparagraph (A) or paragraph (7) of  
28 subdivision (a). Forms printed pursuant to this subdivision that are printed by a computerized

1 prescription generation system may contain the prescriber's name, category of professional  
2 licensure, license number, federal controlled substance registration number, and the date of the  
3 prescription.

4 "(d) Within the next working day following delivery, a security printer shall submit via  
5 web-based application, as specified by the Department of Justice, all of the following information  
6 for all prescription forms delivered:

7 "(1) Serial numbers of all prescription forms delivered.

8 "(2) All prescriber names and Drug Enforcement Administration Controlled Substance  
9 Registration Certificate numbers displayed on the prescription forms.

10 "(3) The delivery shipment recipient names.

11 "(4) The date of delivery."

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

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

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

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

25 "(2) The prescription shall also contain the address of the person for whom the controlled  
26 substance is prescribed. If the prescriber does not specify this address on the prescription, the  
27 pharmacist filling the prescription or an employee acting under the direction of the pharmacist  
28

1 shall write or type the address on the prescription or maintain this information in a readily  
2 retrievable form in the pharmacy.”

3 26. Health and Safety Code section 111295 states:

4 “It is unlawful for any person to manufacture, sell, deliver, hold, or offer for sale any drug  
5 or device that is adulterated.”

6 **REGULATORY PROVISIONS**

7 27. California Code of Regulations, title 16, section 1714 states, in pertinent part:

8 . . . .

9 “(d) Each pharmacist while on duty shall be responsible for the security of the prescription  
10 department, including provisions for effective control against theft or diversion of dangerous  
11 drugs and devices, and records for such drugs and devices. Possession of a key to the pharmacy  
12 where dangerous drugs and controlled substances are stored shall be restricted to a pharmacist.”

13 “(e) The pharmacy owner, the building owner or manager, or a family member of a  
14 pharmacist owner (but not more than one of the aforementioned) may possess a key to the  
15 pharmacy that is maintained in a tamper evident container for the purpose of 1) delivering the key  
16 to a pharmacist or 2) providing access in case of emergency. An emergency would include fire,  
17 flood or earthquake. The signature of the pharmacist-in-charge shall be present in such a way that  
18 the pharmacist may readily determine whether the key has been removed from the container.”

19 28. California Code of Regulations, title 16, section 1716 states:

20 “Pharmacists shall not deviate from the requirements of a prescription except upon the prior  
21 consent of the prescriber or to select the drug product in accordance with Section 4073 of the  
22 Business and Professions Code. Nothing in this regulation is intended to prohibit a pharmacist  
23 from exercising commonly-accepted pharmaceutical practice in the compounding or dispensing  
24 of a prescription.”

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

26 “(a) No pharmacist shall compound or dispense any prescription which contains any  
27 significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any  
28

1 such prescription, the pharmacist shall contact the prescriber to obtain the information needed to  
2 validate the prescription.

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

### 6 **DRUG CLASSIFICATIONS**

7 30. OxyContin, which is a brand name for oxycodone, is a Schedule II controlled  
8 substance and a dangerous drug pursuant to Health and Safety Code section 11055, subdivision  
9 (b)(1)(M), and Code section 4022. OxyContin is indicated for moderate to severe pain.

10 31. Xanax, which is a brand name for alprazolam, is a Schedule IV controlled substance  
11 and a dangerous drug pursuant to Health and Safety Code section 11057, subdivision(d)(1), and  
12 Code section 4022. Xanax is indicated for anxiety.

13 32. Soma, which is a brand name for carisoprodol, is a Schedule IV controlled substance  
14 and a dangerous drug pursuant to California Code of Regulations, title 21, section 1308.14,  
15 subdivision (c)(7), and Code section 4022. Soma is indicated for musculoskeletal conditions.

16 33. Phenergan with Codeine syrup, which is a brand name for promethazine with codeine  
17 syrup, is a Schedule V controlled substance and a dangerous drug pursuant to Health and Safety  
18 Code section 11058, subdivision (c)(1); and Code section 4022. Phenergan with Codeine syrup is  
19 indicated for cough.

20 34. Zosyn, which is a brand name for piperacillin 2 gm with tazobactam 375 mg, is an IV  
21 antibiotic and a dangerous drug pursuant to Code section 4022.

22 35. Vancocin, which is a brand name for vancomycin, is an IV antibiotic and a dangerous  
23 drug pursuant to Code section 4022.

24 36. Cleocin, which is a brand name for clindamycin, is an IV, oral, or topical antibiotic,  
25 and is a dangerous drug pursuant to Code section 4022.

26 37. Rocephin, which is a brand name for ceftriaxone, is an IV antibiotic and a dangerous  
27 drug pursuant to Code section 4022.

28 ///

1           38. Estrace, which is a brand name for estradiol, and is a dangerous drug pursuant to  
2 Code section 4022. Estrace is indicated for estrogen replacement.

3           39. Niaspan, which is a brand name for niacin extended-release, and is a dangerous drug  
4 pursuant to Code section 4022. Niaspan is indicated for dyslipidemia.

5           40. Deltasone, which is a brand name for prednisone, and is a dangerous drug pursuant to  
6 Code section 4022. Deltasone is indicated for allergic states.

7           41. Janumet XR, which is a brand name for sitagliptin and metformin, and is a dangerous  
8 drug pursuant to Code section 4022. Janumet XR is indicated for diabetes.

9           42. Lovenox, which is a brand name for enoxaparin, and is a dangerous drug pursuant to  
10 Code section 4022. Lovenox is indicated for deep vein thrombosis.

11           43. Pneumovax 23, which is a brand name for pneumococcal polysaccharide vaccine, 23-  
12 valent, and is a dangerous drug pursuant to Code section 4022. Pneumovax 23 is indicated for  
13 prevention of pneumococcal disease.

14           44. Fluvirin, which is a brand name for influenza virus vaccine (inactivated), and is a  
15 dangerous drug pursuant to Code section 4022. Fluvirin is indicated for prevention of influenza.

16           45. Byetta, which is a brand name for exenatide, and is a dangerous drug pursuant to  
17 Code section 4022. Byetta is indicated for diabetes.

18           46. Lotrel, which is a brand name for amlodipine/benazepril, and is a dangerous drug  
19 pursuant to Code section 4022. Lotrel is indicated for high blood pressure.

20           47. Roxycodone, sold under the generic name oxycodone, is a Schedule II controlled  
21 substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M) and a  
22 dangerous drug pursuant to Business and Professions Code section 4022.

23           48. Hydrocodone-Acetaminophen 10/325, sold under the brand name Norco is a  
24 Schedule II controlled is substance pursuant to Health and Safety Code section 11055,  
25 subdivision (b)(1)(l)(ii), and a dangerous drug pursuant to Business and Professions Code  
26 section 4022.

27 ///

28 ///

1 **COST RECOVERY**

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

6 **BOARD INVESTIGATION REPORT DATED JUNE 13, 2017**

7 50. On or about July 21, 2016, a Board Inspector conducted an investigation regarding  
8 respondent Pharmacy, which included an inspection of the pharmacy. The Board Inspector  
9 obtained documents from respondent Pharmacy, along with others from reliable sources, and  
10 thereafter determined that violations of Pharmacy Law occurred.

11 51. On July 21, 2016, during a routine inspection by the Board, the Board Inspector  
12 determined that respondent Pharmacy had failed to have in place a current written policy or  
13 procedures for impaired licensed employees. On or about December 3, 2008, respondent  
14 Pharmacy had previously been issued a Notice of Correction for failing to have a policy and  
15 procedures in place for impaired licensed persons. On or about June 21, 2011, respondent  
16 Pharmacy was again issued a Notice of Correction for failing to have a policy and procedures in  
17 place for impaired licensed persons. However, respondent Pharmacy and respondent  
18 Mohammadi failed to establish compliance. As of the Board inspection on July 21, 2016, when  
19 respondent Mohammadi was the PIC of respondent Pharmacy, compliance still had not been  
20 established.

21 52. The Board investigation further determined that on or about July 21, 2016, respondent  
22 Pharmacy, with respondent Mohammadi as PIC, had in its active stock Estradiol 1 mg with an  
23 expiration date of June 30, 2016; Niaspan 1000 mg with an expiration date of July 1, 2016;  
24 Niaspan 750 mg with an expiration date of March 25, 2016; Prednisone 1 mg with an expiration  
25 date of June 30, 2016; Janumet XR 100/1000 mg with an expiration date of November 30, 2015;  
26 Enoxaparin 60 mg/0.6 ml with an expiration date of March 31, 2016; Pneumovax 23 with an  
27 expiration date of March 3, 2014; Fluvirin with an expiration date of May 31, 2014;  
28 Amlodipine/Benzapril 10/20 mg with an expiration date of June 30, 2016; and Byetta 10 mcg

1 with an expiration date of January 31, 2014.

2 **FIRST CAUSE FOR DISCIPLINE**

3 **(Failure to Have Theft or Impairment Policy)**

4 **(As to respondents Pharmacy and Mohammadi)**

5 53. Respondent Pharmacy and respondent Mohammadi are subject to disciplinary action  
6 under Code sections 4301, subdivision (o), and 4113, subdivision (c), in conjunction with Code  
7 section 4104, subdivision (c), on the grounds of unprofessional conduct. Complainant hereby  
8 incorporates paragraphs 50-52 above as though set forth in full herein.

9 **SECOND CAUSE FOR DISCIPLINE**

10 **(Holding and/or Offering for Sale Adulterated Drugs)**

11 **(As to Respondents Pharmacy and Mohammadi)**

12 54. Respondent Pharmacy and respondent Mohammadi are subject to disciplinary action  
13 under Code sections 4301, subdivision (o), and 4113, subdivision (c), in conjunction with Health  
14 and Safety Code section 111295, on the grounds of unprofessional conduct. Complainant hereby  
15 incorporates paragraphs 50-52 above as though set forth in full herein.

16 **BOARD INVESTIGATION REPORT DATED FEBRUARY 10, 2018**

17 55. From December 2016 through early February 2017, the Board conducted a series of  
18 investigations regarding respondent Pharmacy. Respondent Pharmacy's controlled substances  
19 log, prescription copies, Patient Activity Reports (PARs) and other documents revealed violations  
20 of Pharmacy Law.

21 56. The Board investigation determined that between July 20, 2013 and July 20, 2016,  
22 respondent Pharmacy, respondent Ghadishah, and respondent Mohammadi dispensed  
23 prescriptions for controlled substances that were erroneous, uncertain, and/or fraudulent, under  
24 the prescribing authority of Dr. Prosser and Dr. Piety. Respondent Ghadishah was the PIC of  
25 respondent Pharmacy from May 1, 2014 to November 1, 2015. Respondent Mohammadi was the  
26 PIC of respondent Pharmacy from November 16, 2015 to August 26, 2016. The table below lists  
27 some of the fraudulent prescriptions filled at respondent Pharmacy:

28 ///

Script No.	RX No.	Date Written	Date Processed	Patient Name	Drugs Prescribed (Quantity)	Prescriber
8 0204	578697 578698	3/24/2015	3/25/2015	L.D.	Oxycodone 30mg(120); ibuprofen 600mg (30)	Dr. Prosser
9 0706	579371 579372 579370	4/6/2015	4/13/2015	A.S.	Oxycodone 30mg (120); Xanax 2mg (60); Phenergan w/codeine (480ml)	Dr. Prosser
9 0728	579206 579207 579208	4/7/2015	4/7/2015	M.E.	Oxycodone 30mg (120); Xanax 2mg (60); Phenergan w/Codeine (240ml)	Dr. Prosser
9 0722	579618 579619 579620	4/9/2015	4/16/2015	T.F.	Oxycodone 30mg (120); Xanax 2mg (60); Phenergan w/Codeine (480ml)	Dr. Prosser
9 0746	579953 579960 579952	4/20/2015	4/28/2015	M.P.	Oxycodone 30mg (120); Xanax 2mg (60); Phenergan w/Codeine (240ml)	Dr. Prosser
2 0654	579918 579919 579920	4/23/2015	4/27/2015	L.B.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (21)	Dr. Piety
9 0334	580434 580435 580436	5/6/2015	5/12/2015	M.E.	Oxycodone 30mg (120); Xanax 2mg (60); Phenergan w/Codeine (240ml)	Dr. Prosser
2 0663	580427 580428 580429	5/6/2015	5/12/2015	W.H.	Oxycodone 30mg (120); Xanax 2mg (60); Phergan w/Codeine (240ml)	Dr. Priety
2 0678	580630 580631 580632	5/13/2015	5/18/2015	R.J.	Oxycodone 30mg (120); Xanax 2mg (60); Ibuprofen 600mg (90)	Dr. Piety

1	2 0682	580627	5/13/2015	5/18/2015	J.P.	Oxycodone 30mg (120); Xanax 2mg (60); Ibuprofen 600mg (90)	Dr. Piety
2							
3	2 0685	580680 580681 580679	5/13/2015	5/19/2015	T.R.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
4							
5							
6							
7	2 0972	581441 581442 581444	6/3/2015	6/8/2015	M.E.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
8							
9							
10	2 0977	581597 581598 581599	6/3/2015	6/10/2015	L.D.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
11							
12							
13							
14	2 0987	581742 581743 581744	6/10/2015	6/15/2015	A.S.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
15							
16							
17	3 0762	582330 582331 582332	6/16/2015	6/30/2015	M.M.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
18							
19							
20							
21	1 0162	582340 582341 582342	6/29/2015	6/30/2015	M.P.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
22							
23							
24							
25	3 0792	583051 583052 583053	7/8/2015	7/16/2015	T.F.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
26							
27							
28							

1	3 0786	582954 582955	7/8/2015	7/14/2015	S.C.	Oxycodone 30mg (120); Phenergan w/Codeine (480ml); Amoxicillin 500mg (20)	Dr. Piety
2							
3							
4	3 0796	582882 582883 582884	7/8/2015	7/13/2015	M.E.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
5							
6							
7							
8	3 0798	582944 582945 582946	7/8/2015	7/14/2015	D.J.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
9							
10							
11	1 0186	583308 583309 583312	7/15/2015	7/23/2015	L.D.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
12							
13							
14							
15	3 0814	583305 583306 583307	7/22/2015	7/23/2015	A.S.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Xanax 2mg (60)	Dr. Piety
16							
17							
18	3 0810	583318 583319 583320	7/22/2015	7/23/2015	J.P.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Ibuprofen 600mg (90)	Dr. Piety
19							
20							
21							
22	3 0811	593475 583476 583477	7/22/2015	7/28/2015	L.M.	Oxycodone 30mg (120); Phenergan w/Codeine (480ml); Xanax 2mg (60)	Dr. Piety
23							
24							
25	3 0840	584412 584413 584414	8/19/2015	8/20/2015	M.E.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
26							
27							
28							

1	3 0034	584644 584645 584646	8/26/2015	8/27/2015	D.J.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
2							
3							
4	3 0035	584650 584651 584652	8/26/2015	8/27/2015	J.P.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
5							
6							
7							
8	1 0144	584641 584642 584643	8/26/2015	8/27/2015	A.S.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
9							
10							
11							
12	3 0033	584805 584806 584807	8/26/2015	9/1/2015	T.F.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
13							
14							
15							
16	1 0204	584897 584898 584899	9/1/2015	9/2/2015	L.M.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
17							
18							
19	1 0208	585693 585694 585695	9/25/2015	9/25/2015	A.S.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
20							
21							
22							
23	1 0222	585786	9/29/2015	9/30/2015	L.M.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
24							
25							
26	1 0238	586380 586382 586383	10/12/2015	10/14/2015	T.F.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Xanax 2mg (60)	Dr. Prosser
27							
28							

1	3 0418	590504 590505 590506	2/15/2016	2/16/2016	T.F.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
2							
3							
4	3 0426	590689 590690 590691	2/18/2016	2/22/2016	T.R.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
5							
6							
7							
8	5 0103	592949 592951 592950	4/18/2016	4/22/2016	L.Y.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
9							
10							
11	3 0211	593983 593984 593985	5/19/2016	5/20/2016	T.R.	Oxycodone 30mg (120); Phenergan w/Codeine (480ml); Amoxicillin 500mg (20)	Dr. Prosser
12							
13							
14							
15	5 0212	595031	6/20/2016	6/21/2016	R.J.	Oxycodone 30mg (180); Ibuprofen 800mg (90)	Dr. Piety
16							
17	3 0800	582960	7/8/2015	7/14/2015	S.C.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
18							
19							
20							
21	SPACE INTENTIONALLY LEFT BLANK						
22	9 0741	579755	4/20/2015	4/21/2015	S.C.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
23							
24							
25							
26	3 0786	582953	7/8/2015	7/14/2015	S.C.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
27							
28							

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	1 0149	584840	9/1/2015	9/1/2015	A.C.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
16 17 18 19 20 21 22 23 24 25 26 27 28	3 0752	581954	6/16/2015	6/22/2015	L.B.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety
	9 0743	579751	4/20/2015	4/21/2015	S.C.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Prosser
	3 0841	584400	8/19/2015	8/20/2015	S.C.	Oxycodone 30mg (120); Phenergan w/Codeine (240ml); Amoxicillin 500mg (20)	Dr. Piety

57. The Board investigation further determined that that between July 20, 2013, and July 20, 2016, respondent Pharmacy and respondent Ghadishah failed to exercise or implement their best professional judgment or failed to exercise or implement their corresponding responsibility to ensure that controlled substances were dispensed for a legitimate medical purpose. They failed to evaluate the totality of the circumstances to determine whether controlled substances prescriptions they filled and dispensed served legitimate medical purposes, including evaluating information from and about the patients receiving prescriptions for controlled substances, information from and about the physicians prescribing those controlled substances, and information about how the medications prescribed related to patients' diagnoses and their overall course of treatment. They also ignored information available to them that could have helped them determine whether the controlled substance prescriptions they filled were for legitimate medical purpose. Respondent Ghadisha was the PIC of respondent Pharmacy during the period between May 1, 2014 and November 1, 2015.

1           58. As part of its investigation from December 2016 to February 2017, Board Inspectors  
2 reviewed the pharmacy’s drug inventories, its drug usage reports, selected patient prescription  
3 profiles, drug acquisition records, and reviewed reports from the Controlled Substances  
4 Utilization Review and Evaluation System, also known as CURES.

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

10           60. Health and Safety Code section 11165 requires pharmacies to report within seven (7)  
11 days to the California Department of Justice every schedule II, III and IV drug prescription that is  
12 written or dispensed, and the information provided establishes the CURES database, which  
13 includes information about the drug dispensed, drug quantity and strength, patient name, address,  
14 prescriber name, and prescriber authorization number including DEA number and prescription  
15 number. (See Health & Safety Code section 11165.) (*In the Matter of the Accusation Against*  
16 *Pacifica Pharmacy; Thang Tran, supra*, at p. 6.) The CURES database is intended to allow  
17 licensed healthcare prescribers and pharmacists the ability to access patient controlled substance  
18 history information. (See Health and Safety Code section 11165, and Code section 209 [requiring  
19 DOJ and the Department of Consumer Affairs to streamline process to allow licensed health care  
20 practitioners and pharmacists to access CURES and run reports.]

21           61. The following factors are some that have been determined to constitute red flags that  
22 should give a pharmacy and pharmacist inquiry notice of a potential problem with prescriptions  
23 for drugs of common abuse and invoke in them a duty of inquiry:

- 24           • Irregularities on the face of the prescription itself
- 25           • Nervous patient demeanor
- 26           • Age or presentation of patient (e.g. youthful patients seeking chronic pain  
27 medications)
- 28           • Multiple patients at the same address

- 1 • Cash payments
- 2 • Requests for early refills of prescriptions
- 3 • Prescriptions written for an unusually large quantity of drugs
- 4 • Prescriptions written for potentially duplicative drugs
- 5 • The same combinations of drugs prescribed for multiple patients
- 6 • Initial prescriptions written for strong opiates (e.g. OxyContin 80 mg)
- 7 • Long distances traveled from the patient's home, to the prescriber's office or
- 8 pharmacy
- 9 • Irregularities in the prescriber's qualifications in relation to the medication(s)
- 10 prescribed
- 11 • Prescriptions that are written outside of the prescriber's medical specialty
- 12 • Prescriptions for medications with no logical connection to diagnosis or treatment

13 62. Board Inspectors reviewed the CURES report for respondent Pharmacy for the period  
 14 of July 20, 2013 through July 20, 2016. The records provided included all controlled substance  
 15 prescriptions (Schedule II-IV) filled at respondent Pharmacy within that time frame.

16 63. According to the CURES data, respondent Pharmacy filled 5,230 controlled  
 17 substance prescriptions (Schedule II-IV) during the query period. Out of these 5,230 controlled  
 18 substance prescriptions, 1,572 were filled for generic oxycodone (Schedule II controlled  
 19 substance); and 12 were filled for OxyContin (Schedule II controlled substance); and 1,428 were  
 20 filled for generic alprazolam (Schedule IV controlled substance). Out of 1,572 generic  
 21 oxycodone prescriptions, 1,559 were filled for generic oxycodone 30 mg (which was 99.1% of  
 22 the total number of prescriptions filled for generic oxycodone). Because the majority of the  
 23 prescriptions were filled for generic oxycodone 30 mg (a higher strength of oxycodone usually  
 24 used for an opioid tolerant patient), it was a factor of irregularity or red flag for a prescriber to  
 25 initially prescribe oxycodone 30 mg instead of 5 to 15 mg, which was then titrated (adjusted)  
 26 based on the individual patient's response to the initial dose.

27 64. During the query period (based on the CURES data), approximately 24.41% of  
 28 generic oxycodone 30 mg prescriptions and 17.65% of alprazolam 2 mg prescriptions filled at

1 respondent Pharmacy were paid for by billing prescription insurance. Approximately 35.81% of  
 2 generic oxycodone 30 mg, and 22.02% of alprazolam prescriptions were paid for in “cash,”  
 3 meaning without the assistance of prescription insurance. Because of the higher percentage of  
 4 prescriptions filled as cash for oxycodone 30 mg and alprazolam 2 mg compared to billing  
 5 insurances, this was a factor of irregularity or red flag.

6 65. During the query period, Dr. Goldstein’s oxycodone 30 mg prescriptions filled at  
 7 Respondent Pharmacy by different patients, located at different addresses, had script numbers  
 8 which were in consecutive order. These consecutively numbered prescriptions were all  
 9 prescribed on the same day, and the majority of the prescriptions were filled for different patients  
 10 on the same day, as shown in the table below:

11 a. Table: Prescriptions filled at respondent Pharmacy that had script numbers in  
 12 consecutive order.

Patient	Date Prescribed	Script Number	Medication Prescribed and Quantity	Prescription Number	Dated Processed/Filled by Respondent Pharmacy
Alvin B.	10/9/2015	6742	Oxycodone 30mg #150; Phenergan w/Codeine 6oz	586329 586330	10/13/2015 10/13/2015
Abel C.	10/9/2015	6743	Oxycodone 30mg #150; Phenergan w/Codeine 6oz	586314 586315	10/13/2015 10/13/2015
Angela C.	10/9/2015	6744	Oxycodone 30mg #120; Phenergan w/Codeine 16oz	586320 586321	10/13/2015 10/13/2015
Claudell G.	10/9/2015	6746	Oxycodone 30mg #120; Phenergan w/Codeine 16oz	586311 586312	10/13/2015 10/13/2015

1	Claudia F.	10/13/2015	6636	Oxycodone 30mg #120; Xanax 2mg #60; Phenergan w/Codeine 10oz	586554 586555 586556	10/19/2015 10/19/2015 10/19/2015
2						
3						
4	Elba R.	10/13/2015	6637	Oxycodone 30mg #120; Xanax 2mg #60; Phenergan w/Codeine 16oz	586547 586548	10/19/2015 10/19/2015
5						
6						
7						
8	Andrea S.	10/14/2015	6752	Oxycodone 30mg #130; Phenergan w/Codeine 16oz; Xanax 2mg #60	586439 586440 586441	10/15/2015 10/15/2015 10/15/2015
9						
10						
11	Linda Y.	10/14/2015	6753	Oxycodone 30mg #120; Phenergan w/Codeine 16oz; Soma 350mg #60	586374 586375 586376	10/14/2015
12						
13						
14	Michell H.	10/14/2015	6754	Oxycodone 30mg #120; Phenergan w/Codeine 16oz	586472 586473 586474	10/16/2015
15						
16						
17	Mario M.	10/14/2015	6755	Oxycodone 30mg #120; Phenergan w/Codeine 16oz	586371 586372	10/14/2015
18						
19	Tyrone R.	10/14/2015	6756	Oxycodone 30mg #120; Phenergan w/Codeine 16oz; Soma 350mg #60	586377 586378 586379	10/14/2015
20						
21						
22	James P.	10/13/2015	6757	Oxycodone 30mg #130; Phenergan w/Codeine 16oz	586458 586459	10/15/2015
23						
24						
25	Ariel E.	10/14/2015	6758	Oxycodone 30mg #120; Phenergan w/Codeine 16oz	586442 586443	10/15/2015
26						
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1	Dejon A.	10/15/2015	6799	Oxycodone 30mg #120; Phenergan w/Codeine 16oz	586616 586617	10/20/2015
2						
3	Kiemia C.	10/15/2015	6800	Oxycodone 30mg #150; Phenergan w/Codeine 8oz; Xanax 2mg #60	586613 586614 586615	10/20/2015
4						
5						
6	Steve C.	10/23/2015	6674	Oxycodone 30mg #130; Phenergan w/Codeine 8oz; Xanax 2mg #60	587044 587045 587046	11/3/2015
7						
8						
9	Shawtrice C.	10/23/2015	6678	Oxycodone 30mg #120; Phenergan w/Codeine 8oz	587050 587051	11/3/2015
10						
11						
12	Michelle P.	10/23/2015	6679	Oxycodone 30mg #130; Phenergan w/Codeine 16oz; Soma 350mg #60	587041 587042 587043	11/3/2015
13						
14						
15	Andrea S.	10/23/2015	6680	Oxycodone 30mg #120; Phenergan w/Codeine 8oz	587038 587039	11/3/2015
16						
17						
18	Lakecha D.	10/23/2015	6681	Oxycodone 30mg #130; Phenergan w/Codeine 8oz; Xanax 2mg #60	587047 587048 587049	11/3/2015
19						
20						
21	Denise J.	10/23/2015	6682	Oxycodone 30mg #120; Phenergan w/Codeine 8oz	587271 587272	11/9/2015
22						
23	Marsha E.	10/23/2015	6684	Oxycodone 30mg #150; Phenergan w/Codeine 16oz; Soma 350mg #60	587035 587036 587037	11/3/2015
24						
25						
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1	Curley D.	10/23/2015	6686	Oxycodone 30mg #150; Phenergan w/Codeine 16oz	587249 587250	11/9/2015
2						
3	Shawntrice C.	12/15/2015	4518	Oxycodone 30mg #150; Phenergan w/Codeine 8oz; Xanax 2mg #60	588227 588428 588429	12/16/2015
4						
5						
6	Tina F.	12/15/15	4520	Oxycodone 30mg #120; Phenergan w/Codeine 8oz	588433 588434	12/16/2015
7						
8						
9	Michelle P.	12/15/2015	4521	Oxycodone 30mg #120; Phenergan w/Codeine 8oz	588436 588437	12/16/2015
10						
11	Latosha B.	12/15/2015	4522	Oxycodone 30mg #120; Xanax 2mg #60	588424 588425	12/16/2015
12						
13						
14	Lakisha M.	12/15/2016	4523	Oxycodone 30mg #120; Xanax 2mg #60	588430 588431	12/16/2015
15						

16 b. Because nearly all of Dr. Goldstein's prescriptions written for different patients and  
17 filled at respondent Pharmacy were in consecutive order (with some of these prescriptions written  
18 for different patients filled by respondent Pharmacy on the same day), it was a factor of  
19 irregularity or red flag, since it was unlikely that prescriptions written in consecutive order, for  
20 different patients, would get filled at one pharmacy, on the same day.

21 66. During the query period, Dr. Goldstein, Dr. Piety, and Dr. Prosser prescribed the  
22 following total count of prescriptions dispensed at respondent Pharmacy, as shown in the table  
23 below:

24 a. Table: Based on CURES, count of oxycodone, alprazolam, and carisoprodol  
25 controlled substance prescriptions prescribed by the following doctors at respondent Pharmacy  
26 from July 20, 2013 to July 20, 2016.

27 ///

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<b>Doctor's Name</b>	<b>Name of Medication</b>	<b>Total Quantity of Prescriptions</b>
Dr. Goldstein	Oxycodone HCL, 30mg, tab	27
	Alprazolam, 2mg, tab	9
	Carisoprodol, 350mg, tab	4
Dr. Piety	Oxycodone HCL, 30mg, tab	105
	Alprazolam, 2mg, tab	14
	Carisoprodol, 350mg, tab	2
Dr. Prosser	Oxycodone HCL, 30mg, tab	57
	Alprazolam, 2mg, tab	17
	Carisoprodol, 350mg, tab	1

67. Because the majority of prescriptions filled at respondent Pharmacy for Dr. Goldstein, Dr. Piety, and Dr. Prosser were written for oxycodone 30mg (a pain reliever) and alprazolam (an anti-anxiety medication), it was a factor of irregularity or red flag for the patients of Dr. Goldstein, Dr. Piety, and Dr. Prosser to suffer from the same ailments necessitating the same combination of medications.

68. Two medications, oxycodone 30 mg, for quantities of 100 to 120 tablets (1,381 prescriptions of oxycodone 30 mg out of 1,572 total prescriptions filled for generic oxycodone); and generic alprazolam 2 mg, for quantities of 30 to 60 tablets (1,026 prescriptions of alprazolam 2 mg) out of 1,428 total prescriptions filled for generic alprazolam) comprised the majority of the controlled substance prescriptions dispensed by respondent Pharmacy during the query period. Because the majority of prescriptions filled at respondent Pharmacy during the query period were dispensed for large quantities of oxycodone 30 mg (the highest strength dosage of the most commonly abused controlled substance) and alprazolam 2 mg (another commonly abused controlled substance) - which were then dispensed to many different patients, this was a factor of irregularity or red flag because it was unlikely for one pharmacy to dispense mostly the same combination of drugs, in this case oxycodone 30 mg and alprazolam 2 mg, to many different patients.

69. After reviewing the CURES data for respondent Pharmacy, Board Inspectors identified patients for Dr. Prosser/Dr. Piety that also had prescriptions issued by Dr. Goldstein, who were obtaining oxycodone 30 mg and were outside of the service area for respondent Pharmacy and/or Dr. Prosser/Dr. Piety. As shown by the table below, these patients were traveling long distances between respondent Pharmacy, the provider and their residence to obtain controlled substances. In most examples, the patients were traveling long distances to both the prescriber and respondent Pharmacy to have their prescriptions filled, which was a factor of irregularity or red flag.

a. Table: Patient, prescriber, and respondent Pharmacy distance evaluation.

Patient Name <sup>1</sup>	Distance: Patient to MD	Distance: Patient to Pharmacy	Distance: MD to Pharmacy <sup>2</sup>
Latosha B.	23.3 miles	12.9 miles	30.7 miles
Angela C.	26.2 miles	10.3 miles	30.7 miles
Shawntrice C.	22.5 miles	12.5 miles	30.7 miles
Steven C.	31.4 miles	22.9 miles	30.7 miles
Lakecha D.	85.1 miles	58.1 miles	30.7 miles
Marsha E.	33.6 miles	1.0 mile	30.7 miles
Ting F.	32.5 miles	2.0 miles	30.7 miles
Willie H.	26.6 miles	10.9 miles	30.7 miles
Rhonda J.	20.1 miles	18.3 miles	30.7 miles
Mario M.	30.2 miles	5.3 miles	30.7 miles
Lakisha R.	15.1 miles	20.7 miles	30.7 miles
Michelle P.	15.1 miles	21.6 miles	30.7 miles
James P.	33.9 miles	5.2 miles	30.7 miles
Tyrone R.	18.6 miles	18.2 miles	30.7 miles
Andre S.	25.3 miles	12.2 miles	30.7 miles
Andrea S.	25.3 miles	12.2 miles	30.7 miles
Linda Y.	30.2 miles	8.6 miles	30.7 miles

b. Prescription blanks for Dr. Goldstein had two or three different addresses listed, which included addresses in the cities of Orange, Van Nuys, and Simi Valley, California. The prescriptions were marked with either the Van Nuys or Simi Valley address. However, all of the prescriptions were typed using Dr. Goldstein's Orange, California address. Dr. Goldstein's

<sup>1</sup> The patients' address information is not provided in the table in order to protect the privacy rights of those individuals.

<sup>2</sup> The Board was unable to fully determine where Dr. Goldstein's office was located, thus only Dr. Piety and Dr. Prosser's office location was used to compare the distance traveled by the patients of Dr. Piety and Dr. Posser to their office and to respondent Pharmacy.

1 location in Orange, California was approximately 45.6 miles away from respondent Pharmacy,  
2 located in Los Angeles, California.

3 70. The factors of irregularity or red flags with respect to the listed practitioners'  
4 prescriptions were such that a prudent pharmacist could have reasonably concluded that these  
5 were not medically legitimate prescriptions. The pharmacist reviewing these prescriptions should  
6 have noted the highly irregular prescribing patterns of the practitioners, the irregular or non-  
7 compliant prescription documents, the distance patients travelled to obtain these prescriptions,  
8 and the patients' profiles consisting almost exclusively of controlled substances, often at the  
9 highest available doses. In addition, the prescribing patterns for Drs. Piety and Prosser appear to  
10 be incongruent with the physicians' specialty listed on the California Medical Board website. For  
11 example, Dr. Piety and Dr. Prosser, both Family Medicine practitioners, prescribed primarily  
12 oxycodone 30 mg, promethazine/codeine cough syrup, and Xanax 2 mg tablets more often than  
13 any other medication during the query period. The red flags in the prescribers' prescriptions  
14 amounted to significant irregularities or uncertainties the pharmacist was required to address. In  
15 addition to these significant irregularities, Drs. Piety and Prosser advised a Board Inspector that  
16 they did not write the prescriptions filled at respondent Pharmacy under their prescribing  
17 authority. It appears then that Drs. Piety and Prosser would have been able to identify these  
18 fraudulent prescriptions if they had been contacted by respondent Pharmacy or respondent  
19 Ghadishah to verify or validate the prescriptions.

20 71. The Board investigation further determined that between July 20, 2013 and July 20,  
21 2016, respondent Pharmacy, respondent Ghadishah, and respondent Mohammadi filled several  
22 controlled substance prescriptions under the prescribing authority of Dr. Goldstein, Dr. Prosser,  
23 and Dr. Priety, for prescriptions that were written on forms which did not comply with Health and  
24 Safety Code section 11162.1, to wit, the check boxes to indicate the number of refills were  
25 omitted from these prescription forms. Respondent Ghadishah was the PIC of respondent  
26 Pharmacy during the period between May 1, 2014 through November 1, 2015.

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1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Dispensing Erroneous, Uncertain, and/or Fraudulent Prescriptions)**

3 **(As to respondents Pharmacy, Ghadishah, and Mohammadi)**

4 72. Respondent Pharmacy, respondent Ghadishah, and respondent Mohammadi are  
5 subject to disciplinary action under Code sections 4301, subdivision (o), and 4113, subdivision  
6 (c), in conjunction with California Code of Regulations, title 16, section 1761, on the grounds of  
7 unprofessional conduct. Complainant hereby incorporates paragraphs 55-56 above as though set  
8 forth in full herein.

9 **FOURTH CAUSE FOR DISCIPLINE**

10 **(Violation of Corresponding Responsibility to Verify Prescriptions)**

11 **(As to respondents Pharmacy and Ghadishah)**

12 73. Respondent Pharmacy and respondent Ghadishah are subject to disciplinary action  
13 under Code sections 4113, 4301, and 4306.5, in conjunction with Health and Safety Code section  
14 11153 and California Code of Regulations, title 16, section 1761, on the grounds of  
15 unprofessional conduct. Complainant hereby incorporates paragraphs 55, and 57-70 above as  
16 though set forth in full herein.

17 **FIFTH CAUSE FOR DISCIPLINE**

18 **(Dispensing of Controlled Substances Based on Non-Compliant Prescription Forms)**

19 **(As to respondents Pharmacy, Ghadishah, and Mohammadi)**

20 74. Respondent Pharmacy, respondent Ghadishah, and respondent Mohammadi are  
21 subject to disciplinary action under Code sections 4113, and 4301, subdivision (j), in conjunction  
22 with Health and Safety Code sections 11162.1 and 11164, on the grounds of unprofessional  
23 conduct. Complainant hereby incorporates paragraphs 61 and 71 above as though set forth in full  
24 herein.

25 **BOARD INVESTIGATION REPORT DATED FEBRUARY 9, 2018**

26 75. From September 2017 through early February 2018, the Board conducted an  
27 investigation of respondent Pharmacy, which included an inspection of respondent Pharmacy.  
28 The Board Inspector obtained documents from respondent Pharmacy, along with others from

1 reliable sources, and thereafter determined that violations of Pharmacy Law occurred.

2 76. The Board investigation determined that respondent Pharmacy failed to ensure that  
3 possession of a key to the pharmacy where dangerous drugs and controlled substances are stored  
4 was restricted to a pharmacist. The Board investigation also determined that respondent  
5 Pharmacy failed to ensure that when a pharmacy owner has possession of a key to the pharmacy  
6 to provide access in case of an emergency, that such key be secured in a tamper-evident  
7 container. Specifically, on or about November 2, 2017, at approximately 9:00 a.m., a Board  
8 Inspector observed pharmacy technician V.N. (TCH V.N.) open respondent Pharmacy before the  
9 arrival of the pharmacist-in-charge at that time. When the pharmacist-in-charge arrived at  
10 respondent Pharmacy, the Board Inspector observed TCH V.N. retrieve a key from an amber vial  
11 and hand the key over to the pharmacist-in-charge, who then unlocked the door to respondent  
12 Pharmacy, where dangerous drugs and/or controlled substances were stored.

13 77. The investigation further determined that respondent Pharmacy dispensed controlled  
14 substances which deviated from the requirements of the prescriptions without the prior consent of  
15 the prescribers. Specifically, a review of respondent Pharmacy's prescription records between  
16 2014 and 2016 revealed that respondent Pharmacy added one additional refill during the process  
17 of transferring five (5) prescriptions from Century Discount Pharmacy to respondent Pharmacy,  
18 as set forth in more detail in the table, below.

19 a. Table: Prescriptions filled at respondent Pharmacy with one additional refill added

20

Rx No.	Date of Service	Date Written	Comment by Board Inspector
581210	6/2/2015	6/2/2015	Rx No. 476954 was transferred from Century Discount Pharmacy to respondent Pharmacy on 6/2/15. Rx No. 476954 was issued on 3/30/15 by Dr. Manavi with two (2) refills. Last refill date was 5/1/2015 and the remaining refill was one. This means the prescription can only dispense one time. After transferring Rx No. 476954, respondent Pharmacy dispensed Rx No. 581210 on 6/2/2015 with one (1) refill, instead of zero (0) refills.

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1	581615	6/10/2015	6/10/2015	Rx No. 479630 was transferred from Century Discount Pharmacy to respondent Pharmacy on 6/10/15. Rx No. 479630 was issued on 6/10/15 by Dr. Zarian with two (2) refills. This means the prescription can only dispense three times. After transferring Rx No. 479630, respondent Pharmacy dispensed Rx No. 581615 on 6/10/2015 with three (3) refills, instead of two (2) refills.
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10	582285	6/29/2015	6/29/2015	Rx No. 477335 was transferred from Century Discount Pharmacy to respondent Pharmacy on 6/29/2015. Rx No. 477335 was issued on 4/13/2015 by Dr. Nourparvar with four (4) refills. Last fill was 6/2/2015 and there were three (3) remaining refills. This means the prescription can only dispense three (3) more times. After transferring Rx No. 477335, respondent Pharmacy dispensed Rx No. 582285 on 6/29/2015 with three (3) refills, instead of two (2) refills.
11				
12				
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14				
15				
16	585320	9/16/2015	9/16/2015	Rx No. 474842 was transferred from Century Discount Pharmacy to respondent Pharmacy on 9/16/2015. Rx No. 474842 was issued on 2/13/2015 by Dr. Azizad with three (3) refills. The last fill date was 8/11/2015 and there were two (2) remaining refills. This means the prescription can only dispense two (2) more times. After transferring Rx No. 474842, respondent Pharmacy dispensed Rx No. 585320 on 9/16/2015 with two (2) refills, instead of one (1) refill.
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22	586697	10/22/2015	10/22/2015	Rx No. 481285 was transferred from Century Discount Pharmacy to respondent Pharmacy on 10/22/2015. Rx No. 586697 was issued on 8/19/2015 by Dr. Cairo with eleven (11) refills. The last refill date was 9/25/2015 and there were ten (10) remaining refills. This means the prescription can only dispense ten (10) more times. After transferring Rx No. 481285, Respondent Pharmacy dispensed Rx No. 586697 on 10/22/2015 with ten (10) refills, instead of nine (9) refills.
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**SIXTH CAUSE FOR DISCIPLINE**

**(Failure to Maintain Security of Pharmacy)**

**(As to respondent Pharmacy)**

78. Respondent Pharmacy is subject to disciplinary action under Code section 4301, subdivisions (j) and (o) and California Code of Regulations, title 16, section 1714 subdivisions (d) and (e). Complainant hereby incorporates paragraphs 75-76 above as though set forth in full herein.

**SEVENTH CAUSE FOR DISCIPLINE**

**(Dispensing Controlled Substances with Variations from Prescriptions)**

**(As to respondent Pharmacy)**

79. Respondent Pharmacy is subject to disciplinary action under Code section 4301, subdivision (o), for violating Code section 4063 and California Code of Regulations, title 16, section 1716. Complainant hereby incorporates paragraphs 75 and 77 above as though set forth in full herein.

**BOARD INVESTIGATION REPORT DATED SEPTEMBER 8, 2020**

80. A Board investigation at another pharmacy determined that John Korzelius, M.D. Physician's Assistant, JE (PA JE), failed to act in the usual course of her professional practice by prescribing controlled substances to patients for illegitimate medical purposes. A review of CURES records by the Board discovered that respondent Pharmacy also dispensed controlled substance prescriptions written under the prescribing authority of PA JE. Accordingly, an internal Board complaint was filed and an investigation of respondent Pharmacy was initiated to evaluate the legitimacy and appropriateness of respondent Pharmacy's dispensing of controlled substances and/or dangerous drugs.

81. This is a second corresponding responsibility case following one completed in February 2018. An internal review by the Board determined respondent Pharmacy potentially continued failing to exercise their corresponding responsibility to only dispense medically legitimate controlled substance prescriptions. The investigation substantiated the allegations and found the pharmacy continued to dispense controlled substances pursuant to orders written on

1 non-compliant controlled substance prescription documents, made multiple prescription errors,  
2 and operated without a pharmacist-in-charge for a period of greater than 30 days.

3 82. The Board Inspector analyzed the CURES data for respondent Pharmacy from April  
4 27, 2017 – April 27, 2020 and identified factors of irregularity or red flags consistent with  
5 possible illegitimate prescribing and indiscriminate pharmacy dispensing pertaining to multiple  
6 other prescribers. Due to the Coronavirus pandemic and shelter-in-place order, the Board  
7 Inspector was unable to perform an inspection at respondent Pharmacy. Hence, on April 29,  
8 2020, the Board Inspector sent an e-mail to respondent Pharmacy requesting the following:

- 9 • Original prescription documents potentially displaying illegitimate prescribing based  
10 on her CURES data analysis.
- 11 • Respondent Pharmacy’s electronic dispensing records from 04/27/2017 - 04/27/2020.
- 12 • Any and all notes pertaining to the requested prescriptions or patients.

13 83. As part of this investigation, the Board Inspector requested and received from  
14 respondent Pharmacy a sample of prescriptions written under the prescribing authority of PA JE  
15 and six physicians, to wit: Bhasker Venkateswaralu, M.D., Joseph Dinglasan, M.D., Jared Piety,  
16 M.D., Rahil Khan, M.D., Randall Gilbert, M.D., and John Korzelius, M.D.

17 84. The following is an analysis of respondent Pharmacy’s electronic dispensing records  
18 from April 27, 2017 through April 27, 2020:

- 19 • Respondent Pharmacy dispensed 60,622 prescriptions.
- 20 • Non-controlled medications: 57,192 prescriptions (94%).
- 21 • Controlled medications: 3,430 prescriptions (6%).
- 22 • The number of non-controlled medications that are commercially available is greater  
23 than controlled medications, therefore, these percentages were not unusual for a retail pharmacy.
- 24 • Payment method for all medications (controlled and non-controlled) dispensed during  
25 the query period was approximately 11% cash and 89% third party (this number includes both  
26 insurance and discount cards, which are essentially considered cash payment).
- 27 • 10% of non-controlled medications were paid for with cash.
- 28 • 39% of controlled medications were paid for with cash.

1           •       The percentage of cash payment for controlled substances was approximately four  
2 times that of non-controlled substances. Typically, patients do not desire to pay high out-of-  
3 pocket costs for medications and therefore prefer the assistance of insurance. The high percentage  
4 of cash payment for controlled medications was irregular for a retail pharmacy.

5           •       65% of the schedule II controlled substance medications were paid for with cash.

6           •       This was almost seven times greater than non-controlled medications and over 1.5  
7 times that of all controlled substances dispensed by respondent Pharmacy, which was a factor of  
8 irregularity or red flag.

9           •       The number one drug dispensed by respondent Pharmacy was the highly abused  
10 schedule II controlled substance, oxycodone 30 mg.

11          •       As previously mentioned, 94% of the drugs dispensed by respondent Pharmacy were  
12 non-controlled substances.

13          •       Schedule II controlled substances only accounted for 3% (1,675/60,622) of the drugs  
14 dispensed by the respondent Pharmacy

15          •       Hence, it was a glaring factor of irregularity or red flag for a schedule II controlled  
16 substance to be the top drug dispensed by respondent Pharmacy.

17          •       It was also a factor of irregularity for one drug, oxycodone 30 mg, to account for 79%  
18 (1,323/1,675) of the schedule II controlled substances dispensed by respondent Pharmacy.

19          •       Oxycodone immediate-release tablets are available in 5, 10, 15, 20 and 30 mg tablets.  
20 All but two oxycodone prescriptions dispensed by respondent Pharmacy were for the highest  
21 strength oxycodone. This was a factor of irregularity or red flag for the following reasons:

22          •       Given oxycodone therapy should be initiated at the lowest effective dosage as the risk  
23 associated with use, especially fatal respiratory depression, increases with higher dosages, one  
24 would expect to find lower doses dispensed by respondent Pharmacy at much greater frequencies.

25          •       Additionally, a great variability exists between patients such as age, weight, drug  
26 allergies, medical histories, tolerance to narcotic medications, and preferences regarding their  
27 drug therapy plan. Due to this interpatient variability, a prescriber would often choose different  
28 strengths of the same medication to treat their patients.

1           •       73% of respondent Pharmacy’s oxycodone prescriptions were paid for with cash,  
2 which was a factor of irregularity or red flag.

3           85.    The two investigations illuminated the level of respondent Pharmacy’s and its  
4 pharmacists' incompetence, negligence and flagrant disregard for the laws adopted by the  
5 California State Board of Pharmacy to protect patients. Respondent Pharmacy and its  
6 pharmacists filled non-compliant controlled substance prescriptions, ignored glaring red flags and  
7 factors of irregularity, dispensed high dose opioids to naive patients and made prescription errors.  
8 After the initial investigation, either respondent Pharmacy did not understand the underlying  
9 principles of red flags and corresponding responsibility and how to apply changes to comply with  
10 pharmacy law, or it and its pharmacists deliberately disregarded them in order to turn a profit  
11 from the illegitimate distribution of controlled substances. In either case, the actions of  
12 respondent Pharmacy were more aligned with those of a pill-mill rather than a legitimate  
13 pharmacy entrusted with the public's well-being and safety.

14           **Allegations against respondent Pharmacy**

15           86.    As documented in the Board Investigation Report dated September 8, 2020, the Board  
16 Inspector determined that between April 27, 2017 and April 27, 2020, respondent Pharmacy  
17 committed multiple violations of Pharmacy Law, as follows.

18           87.    Respondent Pharmacy dispensed at least 1,274 controlled substance prescriptions  
19 (and 122,307.5 units of controlled substances) in the presence of multiple factors of irregularity or  
20 red flags, evidencing that they were not written for legitimate medical purposes. These multiple  
21 factors of irregularity or red flags included the following:

- 22           •       A large percentage of the prescription written by various prescribers were for highly  
23 abused controlled substances.
- 24           •       Utilizing cash payment instead of a third party for controlled substances.
- 25           •       The prescribing profiles of various prescribers being seemingly incongruent with their  
26 self- reported areas of practice on the Board of Medicine's online database. Additionally, their  
27 prescribing patterns were unusually limited, with a small number of commonly abused controlled  
28 substances accounting for a large percentage of the total prescriptions.

1           •       The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to  
2 all patients receiving the medication without regard for interpatient variability. Most of the  
3 prescriptions listed identical quantities and directions for use.

4           •       Multiple patients being diagnosed with similar or identical ailments by the same  
5 prescriber.

6           •       Patients travelling excessive distances between the medical offices of various  
7 prescribers and the pharmacy.

8           •       Patients presenting to the pharmacy with prescriptions for identical controlled  
9 substances, strengths and directions for use. These prescriptions were assigned consecutive or  
10 nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.

11          •       Prescriptions for controlled substances written on prescription documents lacking  
12 multiple security features and failing to comply with HSC section 11162.1.

13          •       Respondent Pharmacy dispensed at least 539 controlled substance prescriptions (and  
14 50,427 tablets of controlled substances) written on non-compliant prescription documents.

15          •       Opioid naïve patients (those who had not filled an opioid for over two months)  
16 presenting with prescriptions for the highest strength oxycodone, 30 mg, and mostly at total daily  
17 doses of almost three times the recommended safe dose.

18          •       Supporting documentation intimated CURES was checked by respondent Pharmacy  
19 to inquire about the controlled substance dispensing histories of the various patients. However,  
20 the information was either inappropriately scrutinized or simply ignored, as respondent Pharmacy  
21 dispensed 446 prescriptions to opioid naïve patients.

22       88.   The Board investigation determined that during the period in question, respondent  
23 Pharmacy dispensed 19 prescriptions with incorrect directions for use and two prescriptions  
24 written for OxyContin 30 mg as oxycodone 30 mg.

25       89.   The Board investigation further determined that during the period in question,  
26 respondent Pharmacy dispensed 539 controlled substance prescriptions which were written on  
27 prescription documents lacking multiple required security features and failing to comply with  
28 Health and Safety Code section 11162.1.

1           90. The Board investigation also determined that according to Board of Pharmacy  
2 records, respondent Pharmacy was operating without a PIC from February 5, 2019 to April 30,  
3 2019.

4           **Allegations against respondent Khalifian**

5           91. As documented in the Board Investigation Report dated September 8, 2020, the Board  
6 Inspector determined that between April 27, 2017 and April 27, 2020, respondent Khalifian  
7 committed multiple violations of Pharmacy Law, as follows.

8           92. While respondent Khalifian was employed as PIC at respondent Pharmacy, the  
9 pharmacy dispensed at least 357 controlled substance prescriptions (and 31,850 units of  
10 controlled substances) in the presence of multiple factors of irregularity or red flags, evidencing  
11 that they were not written for legitimate medical purposes. These multiple factors of irregularity  
12 or red flags included the following:

- 13           • A large percentage of the prescriptions written by various prescribers were for highly  
14 abused controlled substances.
- 15           • Utilizing cash payment instead of a third party for controlled substances.
- 16           • The prescribing profiles of various prescribers being seemingly incongruent with their  
17 self- reported areas of practice on the Board of Medicine's online database. Additionally, their  
18 prescribing patterns were unusually limited, with a small number of commonly abused controlled  
19 substances accounting for a large percentage of the total prescriptions.
- 20           • The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to  
21 all patients receiving the medication without regard for interpatient variability. Most of the  
22 prescriptions listed identical quantities and directions for use.
- 23           • Multiple patients being diagnosed with similar or identical ailments by the same  
24 prescriber.
- 25           • Patients travelling excessive distances between the medical offices of various  
26 prescribers and the pharmacy.

1 • Patients presenting to the pharmacy with prescriptions for identical controlled  
2 substances, strengths and directions for use. These prescriptions were assigned consecutive or  
3 nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.

4 • Opioid naïve patients (those who had not filled an opioid for over two months)  
5 presenting with prescriptions for the highest strength oxycodone, 30 mg, and mostly at total daily  
6 doses of almost three times the recommended safe dose.

7 • Supporting documentation intimated CURES was checked to inquire about the  
8 controlled substance dispensing histories of the various patients. However, the information was  
9 either inappropriately scrutinized or simply ignored as respondent Pharmacy dispensed 114  
10 prescriptions to opioid naïve patients.

11 93. While employed as a pharmacist at respondent Pharmacy, respondent Khalifian  
12 personally dispensed:

13 • At least 190 controlled substance prescriptions (and 16,340 tablets of controlled  
14 substances) in the presence of multiple factors of irregularity or red flags.

15 • At least 53 prescriptions of the highest strength oxycodone, 30 mg, and mostly at total  
16 daily doses of almost three times the recommended safe dose, to opioid naïve patients.

17 94. While employed as a pharmacist at respondent Pharmacy, respondent Khalifian  
18 dispensed one prescription with incorrect directions for use (RX 630155) and two prescriptions  
19 written for Oxycontin 30 mg as oxycodone 30 mg (RXs 625503 and 625856).

20 **Allegations against respondent Ahdoot**

21 95. As documented in the Board Investigation Report dated September 8, 2020, the Board  
22 Inspector determined that between April 27, 2017 and April 27, 2020, respondent Ahdoot  
23 committed multiple violations of Pharmacy Law, as follows.

24 96. While respondent Ahdoot was employed as PIC at Respondent Pharmacy, the  
25 pharmacy dispensed at least 670 controlled substance prescriptions (and 69,357.5 units of  
26 controlled substances) in the presence of multiple factors of irregularity or red flags, evidencing  
27 that they were not written for legitimate medical purposes. These multiple factors of irregularity  
28 or red flags included the following:

- 1           •     A large percentage of the prescriptions written by various prescribers were for highly  
2 abused controlled substances.
- 3           •     Utilizing cash payment instead of a third party for controlled substances.
- 4           •     The prescribing profiles of various prescribers being seemingly incongruent with their  
5 self- reported areas of practice on the Board of Medicine's online database.  Additionally, their  
6 prescribing patterns were unusually limited, with a small number of commonly abused controlled  
7 substances accounting for a large percentage of the total prescriptions.
- 8           •     The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to  
9 all patients receiving the medication without regard for interpatient variability.  Most of the  
10 prescriptions listed identical quantities and directions for use.
- 11          •     Multiple patients being diagnosed with similar or identical ailments by the same  
12 prescriber.
- 13          •     Patients travelling excessive distances between the medical offices of various  
14 prescribers and respondent Pharmacy.
- 15          •     Patients presenting to respondent Pharmacy with prescriptions for identical controlled  
16 substances, strengths and directions for use.  These prescriptions were assigned consecutive or  
17 nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.
- 18          •     Prescriptions for controlled substances written on prescription documents lacking  
19 multiple security features and failing to comply with HSC section 11162.1.
- 20          •     Respondent Pharmacy dispensed at least 539 controlled substance prescriptions (and  
21 50,427 tablets) written on non-compliant prescription documents.
- 22          •     Opioid naïve patients (those who had not filled an opioid for over two months)  
23 presenting with prescriptions for the highest strength oxycodone, 30 mg, and mostly at total daily  
24 doses of almost three times the recommended safe dose.
- 25          •     Supporting documentation intimated CURES was checked to inquire about the  
26 controlled substance dispensing histories of the various patients.  However, the information was  
27 either inappropriately scrutinized or simply ignored as respondent Pharmacy dispensed 253  
28 prescriptions to opioid naïve patients.

1           97. While employed as a pharmacist at respondent Pharmacy, respondent Ahdoot  
2 personally dispensed:

- 3           • At least 229 prescriptions of the highest strength oxycodone, 30 mg, and mostly at  
4 total daily doses of almost three times the recommended safe dose, to opioid naive patients.
- 5           • At least 584 controlled substance prescriptions (and 60,281 units of controlled  
6 substances) in the presence of multiple factors of irregularity or red flags.

7           98. While employed as a pharmacist at respondent Pharmacy, respondent Ahdoot  
8 personally dispensed one prescription with incorrect directions for use (RX 610681).

9           99. While respondent Ahdoot was employed as PIC at respondent Pharmacy, the  
10 pharmacy dispensed 539 controlled substance prescriptions (50,427 tablets) that were written on  
11 prescription documents lacking multiple required security features and failing to comply with  
12 Health and Safety Code section 11162.1.

13           100. While employed as a pharmacist at respondent Pharmacy, respondent Ahdoot  
14 personally dispensed 488 controlled substance prescriptions (45,557 tablets) written on non-  
15 compliant prescription documents.

16           **Allegations against respondent Farzan**

17           101. As documented in the Board Investigation Report dated September 8, 2020, the Board  
18 Inspector determined that between April 27, 2017 and April 27, 2020, respondent Farzan  
19 committed multiple violations of Pharmacy Law, as follows.

20           102. While respondent Farzan was employed as PIC at respondent Pharmacy, the  
21 pharmacy dispensed at least 80 controlled substance prescriptions (and 6,660 tablets of controlled  
22 substances) in the presence of multiple factors of irregularity or red flags, evidencing that they  
23 were not written for legitimate medical purposes. These multiple factors of irregularity or red  
24 flags included the following:

- 25           • A large percentage of the prescriptions written by various prescribers were for highly  
26 abused controlled substances.
- 27           • Utilizing cash payment instead of a third party for controlled substances.

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1 • The prescribing profiles of various prescribers being seemingly incongruent with their  
2 self- reported areas of practice on the Board of Medicine's online database. Additionally, their  
3 prescribing patterns were unusually limited, with a small number of commonly abused controlled  
4 substances accounting for a large percentage of the total prescriptions.

5 • The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to  
6 all patients receiving the medication without regard for interpatient variability. Most of the  
7 prescriptions listed identical quantities and directions for use.

8 • Multiple patients being diagnosed with similar or identical ailments by the same  
9 prescriber.

10 • Patients travelling excessive distances between the medical offices of various  
11 prescribers and the pharmacy.

12 • Patients presenting to the pharmacy with prescriptions for identical controlled  
13 substances, strengths and directions for use. These prescriptions were assigned consecutive or  
14 nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.

15 • Opioid naïve patients (those who had not filled an opioid for over two months)  
16 presenting with prescriptions for the highest strength oxycodone, 30 mg, and mostly at total daily  
17 doses of almost three times the recommended safe dose.

18 • Supporting documentation intimated CURES was checked to inquire about the  
19 controlled substance dispensing histories of the various patients. However, the information was  
20 either inappropriately scrutinized or simply ignored as respondent Farzan dispensed 20  
21 prescriptions to opioid naïve patients.

22 103. While employed as a pharmacist at respondent Pharmacy, respondent Farzan  
23 personally dispensed:

24 • At least 80 controlled substance prescriptions (and 7,020 tablets of controlled  
25 substances) in the presence of multiple factors of irregularity or red flags.

26 • At least 28 prescriptions of the highest strength oxycodone, 30 mg, and mostly at total  
27 daily doses of almost three times the recommended safe dose, to opioid naïve patients.

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1                   **Allegations against respondent Haroonpoor**

2                   104. As documented in the Board Investigation Report dated September 8, 2020, the Board  
3 Inspector determined that between April 27, 2017 and April 27, 2020, respondent Haroonpoor  
4 committed multiple violations of Pharmacy Law, as follows.

5                   105. While employed as a pharmacist at respondent Pharmacy, respondent Haroonpoor  
6 dispensed at least 155 controlled substance prescriptions (and 13,950 tablets of controlled  
7 substances) in the presence of multiple factors of irregularity or red flags, evidencing that they  
8 were not written for legitimate medical purposes. These multiple factors of irregularity or red  
9 flags included the following:

- 10                   • A large percentage of the prescriptions written by various prescribers were for highly  
11 abused controlled substances.
- 12                   • Utilizing cash payment instead of a third party for controlled substances.
- 13                   • The prescribing profiles of various prescribers being seemingly incongruent with their  
14 self- reported areas of practice on the Board of Medicine's online database. Additionally, their  
15 prescribing patterns were unusually limited, with a small number of commonly abused controlled  
16 substances accounting for a large percentage of the total prescriptions.
- 17                   • The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to  
18 all patients receiving the medication without regard for interpatient variability. Most of the  
19 prescriptions listed identical quantities and directions for use.
- 20                   • Multiple patients being diagnosed with similar or identical ailments by the same  
21 prescriber.
- 22                   • Patients travelling excessive distances between the medical offices of various  
23 prescribers and the pharmacy.
- 24                   • Patients presenting to the pharmacy with prescriptions for identical controlled  
25 substances, strengths and directions for use. These prescriptions were assigned consecutive or  
26 nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.

1 • Opioid naïve patients (those who had not filled an opioid for over two months)  
2 presenting with prescriptions for the highest strength oxycodone (30 mg) and mostly at total daily  
3 doses of almost three times the recommended safe dose.

4 • Supporting documentation intimated CURES was checked to inquire about the  
5 controlled substance dispensing histories of the various patients. However, the information was  
6 either inappropriately scrutinized or simply ignored as respondent Haroonpoor dispensed 46  
7 prescriptions to opioid naïve patients.

8 106. While employed as a pharmacist at respondent Pharmacy, respondent Haroonpoor  
9 dispensed 13 prescriptions with incorrect directions for use.

10 **Allegations against respondent Choi**

11 107. As documented in the Board Investigation Report dated September 8, 2020, the Board  
12 Inspector determined that between April 27, 2017 and April 27, 2020, respondent Choi  
13 committed multiple violations of Pharmacy Law, as follows.

14 108. While employed as a pharmacist at respondent Pharmacy, respondent Choi dispensed  
15 at least 65 controlled substance prescriptions (5,790 tablets of controlled substances) in the  
16 presence of multiple factors of irregularity or red flags, evidencing that they were not written for  
17 legitimate medical purposes. These multiple factors of irregularity or red flags included the  
18 following:

- 19 • A large percentage of the prescriptions written by various prescribers were for highly  
20 abused controlled substances.
- 21 • Utilizing cash payment instead of a third party for controlled substances.
- 22 • The prescribing profiles of various prescribers being seemingly incongruent with their  
23 self- reported areas of practice on the Board of Medicine's online database. Additionally, their  
24 prescribing patterns were unusually limited, with a small number of commonly abused controlled  
25 substances accounting for a large percentage of the total prescriptions.
- 26 • The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to  
27 all patients receiving the medication without regard for interpatient variability. Most of the  
28 prescriptions listed identical quantities and directions for use.

- 1 • Multiple patients being diagnosed with similar or identical ailments by the same  
2 prescriber.
- 3 • Patients travelling excessive distances between the medical offices of various  
4 prescribers and the pharmacy.
- 5 • Patients presenting to the pharmacy with prescriptions for identical controlled  
6 substances, strengths and directions for use. These prescriptions were assigned consecutive or  
7 nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.
- 8 • Opioid naïve patients (those who had not filled an opioid for over two months)  
9 presenting with prescriptions for the highest strength oxycodone, 30 mg, and mostly at total daily  
10 doses of almost three times the recommended safe dose.
- 11 • Supporting documentation intimated CURES was checked to inquire about the  
12 controlled substance dispensing histories of the various patients. However, the information was  
13 either inappropriately scrutinized or simply ignored as respondent Choi dispensed 24  
14 prescriptions to opioid naïve patients.

15 109. While employed as a pharmacist at respondent Pharmacy, respondent Choi dispensed  
16 one prescription with incorrect directions for use (RX 622734).

17 **Allegations against respondent Shakeraneh**

18 110. As documented in the Board Investigation Report dated September 8, 2020, the Board  
19 Inspector determined that between April 27, 2017 and April 27, 2020, respondent Shakeraneh  
20 committed multiple violations of Pharmacy Law, as follows.

21 111. While employed as a pharmacist at respondent Pharmacy, respondent Shakeraneh  
22 dispensed at least 61 controlled substance prescriptions (and 5,300 tablets of controlled  
23 substances) in the presence of multiple factors of irregularity or red flags, evidencing that they  
24 were not written for legitimate medical purposes. These multiple factors of irregularity or red  
25 flags included the following:

- 26 • A large percentage of the prescriptions written by various prescribers were for highly  
27 abused controlled substances.
- 28 • Utilizing cash payment instead of a third party for controlled substances.

1           •       The prescribing profiles of various prescribers being seemingly incongruent with their  
2 self-reported areas of practice on the Board of Medicine's online database. Additionally, their  
3 prescribing patterns were unusually limited, with a small number of commonly abused controlled  
4 substances accounting for a large percentage of the total prescriptions.

5           •       The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to  
6 all patients receiving the medication without regard for interpatient variability. Most of the  
7 prescriptions listed identical quantities and directions for use.

8           •       Multiple patients being diagnosed with similar or identical ailments by the same  
9 prescriber.

10          •       Patients travelling excessive distances between the medical offices of various  
11 prescribers and the pharmacy.

12          •       Patients presenting to the pharmacy with prescriptions for identical controlled  
13 substances, strengths and directions for use. These prescriptions were assigned consecutive or  
14 nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.

15          •       Opioid naïve patients (those who had not filled an opioid for over two months)  
16 presenting with prescriptions for the highest strength oxycodone, 30 mg, and mostly at total daily  
17 doses of almost three times the recommended safe dose.

18          •       Supporting documentation intimated CURES was checked to inquire about the  
19 controlled substance dispensing histories of various patients. However, the information was either  
20 inappropriately scrutinized or simply ignored as respondent Shakeraneh dispensed 23  
21 prescriptions to opioid naïve patients.

22           112. While employed as a pharmacist at respondent Pharmacy, respondent Shakeraneh  
23 dispensed three prescriptions with incorrect directions for use (RXs 628862, 628865 and 628869).

24           **Allegations against respondent Khani**

25           113. As documented in the Board Investigation Report dated September 8, 2020, the Board  
26 Inspector determined that between April 27, 2017 and April 27, 2020, respondent Khani  
27 committed multiple violations of Pharmacy Law, as follows.

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1           114. While employed as a pharmacist at respondent Pharmacy, respondent Khani  
2 dispensed at least 65 controlled substance prescriptions (and 7,0565.5 units of controlled  
3 substances) in the presence of multiple factors of irregularity or red flags, evidencing that they  
4 were not written for legitimate medical purposes. These multiple factors of irregularity or red  
5 flags included the following:

- 6           • A large percentage of the prescriptions written by various prescribers were for highly  
7 abused controlled substances.
- 8           • Utilizing cash payment instead of a third party for controlled substances.
- 9           • The prescribing profiles of various prescribers being seemingly incongruent with their  
10 self- reported areas of practice on the Board of Medicine's online database. Additionally, their  
11 prescribing patterns were unusually limited, with a small number of commonly abused controlled  
12 substances accounting for a large percentage of the total prescriptions.
- 13          • The highest strength of oxycodone, 30 mg, was prescribed by various prescribers to  
14 all patients receiving the medication without regard for interpatient variability. Most of the  
15 prescriptions listed identical quantities and directions for use.
- 16          • Multiple patients being diagnosed with similar or identical ailments by the same  
17 prescriber.
- 18          • Patients travelling excessive distances between the medical offices of various  
19 prescribers and the pharmacy.
- 20          • Patients presenting to the pharmacy with prescriptions for identical controlled  
21 substances, strengths and directions for use. These prescriptions were assigned consecutive or  
22 nearly consecutive pharmacy prescription numbers indicating they were processed sequentially.
- 23          • Prescriptions for controlled substances written on prescription documents lacking  
24 multiple security features and failing to comply with HSC section 11162.1.
- 25          • Respondent Khani dispensed at least 35 controlled substance prescriptions (and 3,330  
26 tablets) written on non-compliant prescription documents.

1 • Opioid naïve patients (those who had not filled an opioid for over two months) mostly  
2 presenting with prescriptions for the highest strength oxycodone, 30 mg, at total daily doses of  
3 between three and five times the recommended safe dose.

4 • Supporting documentation intimated CURES was checked to inquire about the  
5 controlled substance dispensing histories of various patients. However, the information was  
6 either inappropriately scrutinized or simply ignored as respondent Khani dispensed 17  
7 prescriptions to opioid naïve patients.

8 115. While employed as a pharmacist at respondent Pharmacy, respondent Khani  
9 dispensed 35 controlled substance prescriptions which were written on prescription documents  
10 lacking multiple required security features and failing to comply with Health and Safety Code  
11 section 11162.1.

12 **Allegations against respondent Azizzadeh**

13 116. As documented in the Board Investigation Report dated September 8, 2020, the Board  
14 Inspector determined that between April 27, 2017 and April 27, 2020, respondent Azizzadeh  
15 committed multiple violations of Pharmacy Law, as follows.

16 117. While employed as a pharmacist at respondent Pharmacy, respondent Azizzadeh  
17 dispensed 16 controlled substance prescriptions which were written on prescription documents  
18 lacking multiple required security features and failing to comply with Health and Safety Code  
19 section 11162.1.

20 118. While employed as a pharmacist at respondent Pharmacy, respondent Azizzadeh  
21 dispensed at least six prescriptions (RXs 617039, 617817, 617822, 617945, 617950 and 617954)  
22 for the highest strength oxycodone, 30 mg, to opioid naïve patients (those who had not filled an  
23 opioid for over two months) at total daily doses of between three and five times the recommended  
24 safe dose. Supporting documentation intimated CURES was checked to inquire about the  
25 controlled substance dispensing histories of the various patients, however, the information was  
26 either inappropriately scrutinized or simply ignored.

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**EIGHTH CAUSE FOR DISCIPLINE**

**(Violation of Corresponding Responsibility to Verify Prescriptions)**

**(As to respondent Pharmacy)**

119. Respondent Pharmacy is subject to disciplinary action under Code sections 4301 and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-87 above as though set forth in full herein.

**NINTH CAUSE FOR DISCIPLINE**

**(Variation from Prescriptions)**

**(As to respondent Pharmacy)**

120. Respondent Pharmacy is subject to disciplinary action under California Code of Regulations, title 16, section 1716, and Code section 4073. Complainant hereby incorporates paragraphs 80-86 and 88 above as though set forth in full herein.

**TENTH CAUSE FOR DISCIPLINE**

**(Dispensed Controlled Substance Prescriptions Written on Prescription Documents Lacking Multiple Required Security Features)**

**(As to respondent Pharmacy)**

121. Respondent Pharmacy is subject to disciplinary action under Health and Safety Code sections 11164, subdivision (a), and 11162.1. Complainant hereby incorporates paragraphs 80-86 and 89 above as though set forth in full herein.

**ELEVENTH CAUSE FOR DISCIPLINE**

**(Operating Without Pharmacist-in-Charge for More Than 30 Days)**

**(As to respondent Pharmacy)**

122. Respondent Pharmacy is subject to disciplinary action under Code sections 4113, subdivision (d), and 4305. Complainant hereby incorporates paragraphs 80-86 and 90 above as though set forth in full herein.

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**TWELFTH CAUSE FOR DISCIPLINE**

**(Violation of Corresponding Responsibility to Verify Prescriptions)**

**(As to respondent Khalifian)**

123. Respondent Khalifian is subject to disciplinary action under Code sections 4113, 4301, and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, and 91-93 above as though set forth in full herein.

**THIRTEENTH CAUSE FOR DISCIPLINE**

**(Variation from Prescriptions)**

**(As to respondent Khalifian)**

124. Respondent Khalifian is subject to disciplinary action under California Code of Regulations, title 16, section 1716, and Code section 4073. Complainant hereby incorporates paragraphs 80-85, 91, and 94 above as though set forth in full herein.

**FOURTEENTH CAUSE FOR DISCIPLINE**

**(Violation of Corresponding Responsibility to Verify Prescriptions)**

**(As to respondent Ahdoot)**

125. Respondent Ahdoot is subject to disciplinary action under Code sections 4113, 4301, and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, and 95-97 above as though set forth in full herein.

**FIFTEENTH CAUSE FOR DISCIPLINE**

**(Variation from Prescriptions)**

**(As to respondent Ahdoot)**

126. Respondent Ahdoot is subject to disciplinary action under California Code of Regulations, title 16, section 1716, and Code section 4073. Complainant hereby incorporates paragraphs 80-85, 95, and 98 above as though set forth in full herein.

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**SIXTEENTH CAUSE FOR DISCIPLINE**

**(Dispensed Controlled Substance Prescriptions Written on Prescription Documents Lacking Multiple Required Security Features)**

**(As to respondent Ahdoot)**

127. Respondent Ahdoot is subject to disciplinary action under Health and Safety Code sections 11164, subdivision (a), and 11162.1. Complainant hereby incorporates paragraphs 80-85, 95, and 99-100 above as though set forth in full herein.

**SEVENTEENTH CAUSE FOR DISCIPLINE**

**(Violation of Corresponding Responsibility to Verify Prescriptions)**

**(As to respondent Farzan)**

128. Respondent Farzan is subject to disciplinary action under Code sections 4113, 4301, and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, and 101-103 above as though set forth in full herein.

**EIGHTEENTH CAUSE FOR DISCIPLINE**

**(Violation of Corresponding Responsibility to Verify Prescriptions)**

**(As to respondent Haroonpoor)**

129. Respondent Haroonpoor is subject to disciplinary action under Code sections 4301 and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, and 104-105 above as though set forth in full herein

**NINETEENTH CAUSE FOR DISCIPLINE**

**(Variation from Prescriptions)**

**(As to respondent Haroonpoor)**

130. Respondent Haroonpoor is subject to disciplinary action under California Code of Regulations, title 16, section 1716, and Code section 4073. Complainant hereby incorporates paragraphs 80-85, 104, and 106 above as though set forth in full herein.

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1 **TWENTIETH CAUSE FOR DISCIPLINE**

2 **(Violation of Corresponding Responsibility to Verify Prescriptions)**

3 **(As to respondent Choi)**

4 131. Respondent Choi is subject to disciplinary action under Code sections 4301 and  
5 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of  
6 Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates  
7 paragraphs 80-85, and 107-108 above as though set forth in full herein

8 **TWENTY-FIRST CAUSE FOR DISCIPLINE**

9 **(Variation from Prescriptions)**

10 **(As to respondent Choi)**

11 132. Respondent Choi is subject to disciplinary action under California Code of  
12 Regulations, title 16, section 1716, and Code section 4073. Complainant hereby incorporates  
13 paragraphs 80-85, 107, and 109 above as though set forth in full herein.

14 **TWENTY-SECOND CAUSE FOR DISCIPLINE**

15 **(Violation of Corresponding Responsibility to Verify Prescriptions)**

16 **(As to respondent Shakeraneh)**

17 133. Respondent Shakeraneh is subject to disciplinary action under Code sections 4301  
18 and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of  
19 Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates  
20 paragraphs 80-85, and 110-111 above as though set forth in full herein.

21 **TWENTY-THIRD CAUSE FOR DISCIPLINE**

22 **(Variation from Prescriptions)**

23 **(As to respondent Shakeraneh)**

24 134. Respondent Shakeraneh is subject to disciplinary action under California Code of  
25 Regulations, title 16, section 1716, and Code section 4073. Complainant hereby incorporates  
26 paragraphs 80-85, 110, and 112 above as though set forth in full herein.

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**TWENTY-FOURTH CAUSE FOR DISCIPLINE**

**(Violation of Corresponding Responsibility to Verify Prescriptions)**

**(As to respondent Khani)**

135. Respondent Khani is subject to disciplinary action under Code sections 4301 and 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, and 113-114 above as though set forth in full herein.

**TWENTY-FIFTH CAUSE FOR DISCIPLINE**

**(Dispensed Controlled Substance Prescriptions Written on Prescription Documents Lacking Multiple Required Security Features)**

**(As to respondent Khani)**

136. Respondent Khani is subject to disciplinary action under Health and Safety Code sections 11164, subdivision (a), and 11162.1. Complainant hereby incorporates paragraphs 80-85, 113, and 115 above as though set forth in full herein.

**TWENTY-SIXTH CAUSE FOR DISCIPLINE**

**(Dispensed Controlled Substance Prescriptions Written on Prescription Documents Lacking Multiple Required Security Features)**

**(As to respondent Azizzadeh)**

137. Respondent Azizzadeh is subject to disciplinary action under Health and Safety Code sections 11164, subdivision (a), and 11162.1. Complainant hereby incorporates paragraphs 80-85, and 116-117 above as though set forth in full herein.

**TWENTY-SEVENTH CAUSE FOR DISCIPLINE**

**(Erroneous or Uncertain Prescriptions)**

**(As to respondent Azizzadeh)**

138. Respondent Azizzadeh is subject to disciplinary action under California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Complainant hereby incorporates paragraphs 80-85, 116, and 118 above as though set forth in full herein.

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**DISCIPLINE CONSIDERATIONS**

139. To determine the degree of discipline, if any, to be imposed on respondent Pharmacy, complainant alleges that on or about April 27, 2005, in a previous matter entitled *In the Matter of the Accusation and First Amended Accusation and Supplemental Accusation against Joseph Amin dba Century Pharmacy and Javad Ferdowsi*, Board of Pharmacy Case No. 2280, the Board issued a citation as to respondent Pharmacy in the amount of \$2,500 for violating the following: Business and Professions Code section 4081, in conjunction with Code of Federal Regulations, title 21, section 1304.21, subdivision (a) [failure to maintain accurate DEA inventory of dangerous drugs/controlled substances] and Business and Professions Code section 4059, subdivision (a) [furnishing a drug or controlled substance without a prescription for a person unlawfully authorized to prescribe]. That citation is now final and is incorporated by reference as if fully set forth herein.

140. To determine the degree of discipline, if any, to be imposed on respondent Pharmacy, with Joseph Amin, as owner, complainant alleges that on or about June 11, 2018, in a previous matter entitled *In the Matter of the Second Amended Accusation against Century Discount Pharmacy, Inc. Farhad D. Sharim and Joseph Amin, owners, et al.*, Board of Pharmacy Case No. 4829, Century Discount Pharmacy, Inc.'s Pharmacy Permit Number PHY 39871 was surrendered. Century Discount Pharmacy, Inc., with Farhad D. Sharim and Joseph Amin, as owners, were ordered to pay the Board its costs of investigation and enforcement in the amount of \$37,199.25 prior to the issuance of a new or reinstated license. That decision is now final and is incorporated by reference as if fully set forth herein.

141. To determine the degree of discipline, if any, to be imposed on respondent Pharmacy, complainant alleges that on or about June 21, 2021, in a previous matter entitled *In the Matter of the Accusation against Joseph Amin dba Century Pharmacy and Javad Ferdowsi*, Board of Pharmacy Case No. 4670, the Board ultimately withdrew its accusation and issued a citation as to respondent Pharmacy in the amount of \$1,000 for the following violations: Code sections 4301(f) and (g); 4113(c) [Insurance Fraud]; Code sections 4301(g) and (o), and 4113(c), in conjunction with Code section 4076(a) [False and Improper Prescription Labels]; Code sections 4301(o), and

1 4113(c), in conjunction with California Code of Regulations, title 16, section 1761 [Dispensing  
2 Erroneous or Uncertain Prescriptions]; Code sections 4301(o), and 4113(c), in conjunction with  
3 Code section 4081(a) [Records of Dangerous Drugs Open for Inspection]; Code sections 4301(o),  
4 and 4113(c), in conjunction with California Code of Regulations, title 16, section 1715 [Failure to  
5 Complete a Self-Assessment]; Code sections 4301(o), and 4113(c), in conjunction with Code of  
6 Federal Regulations, title 16, section 1304.11(a) and (c) [Failure to Keep Controlled Substance  
7 Inventory]; Code sections 4301(o), and 4113(c), in conjunction with Code of Federal Regulations,  
8 title 16, section 1304.04(h) [Failure to Maintain controlled Substance Inventory]; Code sections  
9 4301(o), and 4113(c), in conjunction with Code section 4076(a)(11) [Violation of Prescription  
10 Container Labeling Requirement]; and Code sections 4301(o), and 4113(c), in conjunction with  
11 Code section 4104(b) [Failure to Have Theft or Impairment Policy]. That citation is now final  
12 and is incorporated by reference as if fully set forth herein.

13 142. To determine the degree of discipline, if any, to be imposed on respondent  
14 Ghadishah, complainant alleges that on or about February 28, 2018, the Board issued Citation  
15 Number CI 2017 78968 to respondent Ghadishah for violating Business and Professions Code  
16 section 4063, in conjunction with California Code of Regulations, title 16, section 1716.  
17 Respondent Ghadishah was ordered to pay a fine of \$1,000. That citation is now final and is  
18 incorporated herein by reference as if fully set forth herein.

19 143. To determine the degree of discipline, if any, to be imposed on respondent Choi,  
20 complainant alleges that on or about July 29, 2020, in a previous matter entitled *In the Matter of*  
21 *the Accusation against I.MC16, Inc. dba R & X Compounding Pharmacy, Young Sook Choi,*  
22 *Owner and Young Sook Choi*, Board of Pharmacy Case No. 5922, respondent Choi's Pharmacist  
23 License Number 41950 was surrendered. Respondent Choi was ordered to pay the Board its costs  
24 of investigation and enforcement in the amount of \$55,572.75 prior to the issuance of a new or  
25 reinstated license. The decision is now final and is incorporated herein by reference as if fully set  
26 forth herein.

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**OTHER MATTERS**

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2           144. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number  
3 PHY 34252, issued to Joseph Amin (Amin), doing business as Century Pharmacy, while acting as  
4 the manager, administrator, owner, member, office, director, associate, or partner of Century  
5 Pharmacy, had knowledge of or knowingly participated in any conduct for which Pharmacy  
6 Permit Number PHY 34252, issued to Joseph Amin, doing business as Century Pharmacy was  
7 revoked, suspended or placed on probation, Amin shall be prohibited from serving as a manager,  
8 administrator, owner, member, officer, director, associate, or partner of a licensee for five years if  
9 Pharmacy Permit Number 34252 issued to Joseph Amin, doing business as Century Pharmacy is  
10 placed on probation or until Pharmacy Permit Number PHY 34252 issued to Joseph Amin, doing  
11 business as Century Pharmacy is reinstated if it is revoked.

12           145. Pursuant to Code section 4307, if Pharmacist License Number RPH 70372, issued to  
13 Jila Mohammadi, is disciplined as part of the Board’s Decision, then Jila Mohammadi shall be  
14 prohibited from serving as a manager, administrator, owner, member, officer, director, associate,  
15 partner, or in any other position with management or control of a licensee for a period (1) not to  
16 exceed five years if Pharmacist License Number RPH 70372 is placed on probation as part of the  
17 Board’s decision, or (2) until said license is reinstated if it is revoked as part of the Board’s  
18 decision.

19           146. Pursuant to Code section 4307, if Pharmacist License Number RPH 70585, issued to  
20 Morris Ghadishah, is disciplined as part of the Board’s Decision, then Morris Ghadishah shall be  
21 prohibited from serving as a manager, administrator, owner, member, officer, director, associate,  
22 partner, or in any other position with management or control of a licensee for a period (1) not to  
23 exceed five years if Pharmacist License Number RPH 70585 is placed on probation as part of the  
24 Board’s decision, or (2) until said license is reinstated if it is revoked as part of the Board’s  
25 decision.

26           147. Pursuant to Code section 4307, if Pharmacist License Number RPH 44675, issued to  
27 Mahshid Paya Khalifian, is disciplined as part of the Board’s Decision, then Mahshid Paya  
28 Khalifian shall be prohibited from serving as a manager, administrator, owner, member, officer,

1 director, associate, partner, or in any other position with management or control of a licensee for a  
2 period (1) not to exceed five years if Pharmacist License Number RPH 44675 is placed on  
3 probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as  
4 part of the Board's decision.

5 148. Pursuant to Code section 4307, if Pharmacist License Number RPH 43292, issued to  
6 Mehrdad Ahdoot, is disciplined as part of the Board's Decision, then Mehrdad Ahdoot shall be  
7 prohibited from serving as a manager, administrator, owner, member, officer, director, associate,  
8 partner, or in any other position with management or control of a licensee for a period (1) not to  
9 exceed five years if Pharmacist License Number RPH 43292 is placed on probation as part of the  
10 Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's  
11 decision.

12 149. Pursuant to Code section 4307, if Pharmacist License Number RPH 44807, issued to  
13 Shiva Kiaee Farzan, is disciplined as part of the Board's Decision, then Shiva Kiaee Farzan shall  
14 be prohibited from serving as a manager, administrator, owner, member, officer, director,  
15 associate, partner, or in any other position with management or control of a licensee for a period  
16 (1) not to exceed five years if Pharmacist License Number RPH 44807 is placed on probation as  
17 part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the  
18 Board's decision.

19 150. Pursuant to Code section 4307, if Pharmacist License Number RPH 76314, issued to  
20 Shirin Haroonpoor, is disciplined as part of the Board's Decision, then Shirin Haroonpoor shall  
21 be prohibited from serving as a manager, administrator, owner, member, officer, director,  
22 associate, partner, or in any other position with management or control of a licensee for a period  
23 (1) not to exceed five years if Pharmacist License Number RPH 76314 is placed on probation as  
24 part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the  
25 Board's decision.

26 151. Pursuant to Code section 4307, if Pharmacist License Number RPH 41950, issued to  
27 Young Sook Choi, is disciplined as part of the Board's Decision, then Young Sook Choi shall be  
28 prohibited from serving as a manager, administrator, owner, member, officer, director, associate,

1 partner, or in any other position with management or control of a licensee for a period (1) not to  
2 exceed five years if Pharmacist License Number RPH 41950 is placed on probation as part of the  
3 Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's  
4 decision.

5 152. Pursuant to Code section 4307, if Pharmacist License Number RPH 45821, issued to  
6 Hengameh Shakeraneh, is disciplined as part of the Board's Decision, then Hengameh  
7 Shakeraneh shall be prohibited from serving as a manager, administrator, owner, member, officer,  
8 director, associate, partner, or in any other position with management or control of a licensee for a  
9 period (1) not to exceed five years if Pharmacist License Number RPH 45821 is placed on  
10 probation as part of the Board's decision, or (2) until said license is reinstated if it is revoked as  
11 part of the Board's decision.

12 153. Pursuant to Code section 4307, if Pharmacist License Number RPH 54486, issued to  
13 Parisa Khani, is disciplined as part of the Board's Decision, then Parisa Khani shall be prohibited  
14 from serving as a manager, administrator, owner, member, officer, director, associate, partner, or  
15 in any other position with management or control of a licensee for a period (1) not to exceed five  
16 years if Pharmacist License Number RPH 54486 is placed on probation as part of the Board's  
17 decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision.

18 154. Pursuant to Code section 4307, if Pharmacist License Number RPH 53320, issued to  
19 Shirin Azizzadeh, is disciplined as part of the Board's Decision, then Shirin Azizzadeh shall be  
20 prohibited from serving as a manager, administrator, owner, member, officer, director, associate,  
21 partner, or in any other position with management or control of a licensee for a period (1) not to  
22 exceed five years if Pharmacist License Number RPH 53320 is placed on probation as part of the  
23 Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's  
24 decision.

25 **PRAYER**

26 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
27 and that following the hearing, the Board issue a decision:  
28

1           1.     Revoking or suspending Permit Number PHY 34252, issued to Joseph Amin, doing  
2 business as Century Pharmacy;

3           2.     Prohibiting Joseph Amin, pursuant to Business and Professions Code section 4307,  
4 from serving as a manager, administrator, owner, member, officer, director, associate, partner, or  
5 in any other position with management or control of a licensee for a period (1) not to exceed five  
6 years if Pharmacy Permit Number PHY 34252 is placed on probation as part of the Board's  
7 decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision;

8           3.     Revoking or suspending Pharmacist License Number RPH 70372, issued to Jila  
9 Mohammadi;

10          4.     Prohibiting Jila Mohammadi, pursuant to Business and Professions Code section  
11 4307, from serving as a manager, administrator, owner, member, officer, director, associate,  
12 partner, or in any other position with management or control of a licensee for a period (1) not to  
13 exceed five years if Pharmacist License Number RPH 70372 is placed on probation as part of the  
14 Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's  
15 decision;

16          5.     Revoking or suspending Pharmacist License Number RPH 70585, issued to Morris  
17 Ghadishah;

18          6.     Prohibiting Morris Ghadishah, pursuant to Business and Professions Code section  
19 4307, from serving as a manager, administrator, owner, member, officer, director, associate,  
20 partner, or in any other position with management or control of a licensee for a period (1) not to  
21 exceed five years if Pharmacist License Number RPH 70585 is placed on probation as part of the  
22 Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's  
23 decision;

24          7.     Revoking or suspending Pharmacist License Number RPH 44675, issued to Mahshid  
25 Paya Khalifian;

26          8.     Prohibiting Mahshid Paya Khalifian, pursuant to Business and Professions Code  
27 section 4307, from serving as a manager, administrator, owner, member, officer, director,  
28 associate, partner, or in any other position with management or control of a licensee for a period

1 (1) not to exceed five years if Pharmacist License Number RPH 44675 is placed on probation as  
2 part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the  
3 Board's decision;

4 9. Revoking or suspending Pharmacist License Number RPH 43292, issued to Mehrdad  
5 Ahdoot;

6 10. Prohibiting Mehrdad Ahdoot, pursuant to Business and Professions Code section  
7 4307, from serving as a manager, administrator, owner, member, officer, director, associate,  
8 partner, or in any other position with management or control of a licensee for a period (1) not to  
9 exceed five years if Pharmacist License Number RPH 43292 is placed on probation as part of the  
10 Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's  
11 decision;

12 11. Revoking or suspending Pharmacist License Number RPH 44807, issued to Shiva  
13 Kiaee Farzan;

14 12. Prohibiting Shiva Kiaee Farzan, pursuant to Business and Professions Code section  
15 4307, from serving as a manager, administrator, owner, member, officer, director, associate,  
16 partner, or in any other position with management or control of a licensee for a period (1) not to  
17 exceed five years if Pharmacist License Number RPH 44807 is placed on probation as part of the  
18 Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's  
19 decision;

20 13. Revoking or suspending Pharmacist License Number RPH 76314, issued to Shirin  
21 Haroonpoor;

22 14. Prohibiting Shirin Haroonpoor, pursuant to Business and Professions Code section  
23 4307, from serving as a manager, administrator, owner, member, officer, director, associate,  
24 partner, or in any other position with management or control of a licensee for a period (1) not to  
25 exceed five years if Pharmacist License Number RPH 76314 is placed on probation as part of the  
26 Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's  
27 decision;

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1           15. Revoking or suspending Pharmacist License Number RPH 41950, issued to Young  
2 Sook Choi;

3           16. Prohibiting Young Sook Choi, pursuant to Business and Professions Code section  
4 4307, from serving as a manager, administrator, owner, member, officer, director, associate,  
5 partner, or in any other position with management or control of a licensee for a period (1) not to  
6 exceed five years if Pharmacist License Number RPH 41950 is placed on probation as part of the  
7 Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's  
8 decision;

9           17. Revoking or suspending Pharmacist License Number RPH 45821, issued to  
10 Hengameh Shakeraneh;

11           18. Prohibiting Hengameh Shakeraneh, pursuant to Business and Professions Code  
12 section 4307, from serving as a manager, administrator, owner, member, officer, director,  
13 associate, partner, or in any other position with management or control of a licensee for a period  
14 (1) not to exceed five years if Pharmacist License Number RPH 45821 is placed on probation as  
15 part of the Board's decision, or (2) until said license is reinstated if it is revoked as part of the  
16 Board's decision;

17           19. Revoking or suspending Pharmacist License Number RPH 54486, issued to Parisa  
18 Khani;

19           20. Prohibiting Parisa Khani, pursuant to Business and Professions Code section 4307,  
20 from serving as a manager, administrator, owner, member, officer, director, associate, partner, or  
21 in any other position with management or control of a licensee for a period (1) not to exceed five  
22 years if Pharmacist License Number RPH 54486 is placed on probation as part of the Board's  
23 decision, or (2) until said license is reinstated if it is revoked as part of the Board's decision;

24           21. Revoking or suspending Pharmacist License Number RPH 53320, issued to Shirin  
25 Azizzadeh;

26           22. Prohibiting Shirin Azizzadeh, pursuant to Business and Professions Code section  
27 4307, from serving as a manager, administrator, owner, member, officer, director, associate,  
28 partner, or in any other position with management or control of a licensee for a period (1) not to

1 exceed five years if Pharmacist License Number RPH 53320 is placed on probation as part of the  
2 Board's decision, or (2) until said license is reinstated if it is revoked as part of the Board's  
3 decision;

4 23. Ordering Joseph Amin, doing business as Century Pharmacy, Jila Mohammadi,  
5 Morris Ghadishah, Mahshid Paya Khalifian, Mehrdad Ahdoot, Shiva Kiaee Farzan, Shirin  
6 Haroonpoor, Young Sook Choi, Hengameh Shakeraneh, Parisa Khani, and Shirin Azizzadeh,  
7 jointly and severally, to pay the Board the reasonable costs of the investigation and enforcement  
8 of this case, pursuant to Business and Professions Code section 125.3; and

9 24. Taking such other and further action as deemed necessary and proper.

10  
11 DATED: 9/20/2021

Signature on File

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

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**Exhibit A**

**Accusation No. 7005**

1 XAVIER BECERRA  
Attorney General of California  
2 SHAWN P. COOK  
Supervising Deputy Attorney General  
3 NANCY CALERO  
Deputy Attorney General  
4 State Bar No. 261370  
300 So. Spring Street, Suite 1702  
5 Los Angeles, CA 90013  
Telephone: (213) 269-6351  
6 Facsimile: (916) 731-2126  
*Attorneys for Complainant*  
7

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

11 In the Matter of the Accusation Against:

Case No. 7005

12 **CENTURY PICO PHARMACY INC. DBA**  
13 **CENTURY PICO PHARMACY INC.,**  
14 **JOSEPH AMIN, BAHRAM SAMOUHA**  
8722 Pico Blvd  
Los Angeles, CA 90035

**ACCUSATION**

15 **Permit No. PHY 41037,**

16 **HASTI ASHLYN ELAHI**  
313 W. California Ave, #306  
17 Glendale, CA 91203

18 **Pharmacist License No. RPH 79647,**

19 **SHIRIN AZIZZADEH**  
530 Evelyn Pl  
20 Beverly Hills, CA 90210

21 **Pharmacist License No. RPH 53320,**

22 **BAHRAM SAMOUHA**  
311 N. Palm Dr.  
23 Beverly Hills, CA 90210

24 **Pharmacist License No. RPH 45531**

25 **And**  
26  
27  
28

1 **PARISA KHANI**  
2 **P.O. BOX 16025,**  
3 **Beverly Hills, CA 90209**

4 **Pharmacist License No. RPH 54486**

5 Respondents.

6  
7 **PARTIES**

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

10 2. On or about October 24, 1995, the Board of Pharmacy issued Permit Number PHY  
11 41037 to Century Pico Pharmacy Inc. dba Century Pico Pharmacy Inc., Joseph Amin, Bahram  
12 Samouha (Respondent Pico). The Permit was in full force and effect at all times relevant to the  
13 charges brought herein and will expire on October 1, 2021.

14 3. On or about October 12, 2018, the Board of Pharmacy issued Pharmacist License  
15 Number RPH 79647 to Hasti Ashlyn Elahi (Respondent Elahi). The Pharmacist License was in  
16 full force and effect at all times relevant to the charges brought herein and will expire on May 31,  
17 2022, unless renewed.

18 4. On or about March 20, 2002, the Board of Pharmacy issued Pharmacist License  
19 Number RPH 53320 to Shirin Azizzadeh (Respondent Azizzadeh). The Pharmacist License was  
20 in full force and effect at all times relevant to the charges brought herein and will expire on  
21 August 31, 2021, unless renewed.

22 5. On or about August 14, 1992, the Board of Pharmacy issued Pharmacist License  
23 Number RPH 45531 to Bahram Samouha (Respondent Samouha). The Pharmacist License was  
24 in full force and effect at all times relevant to the charges brought herein and will expire on  
25 August 31, 2022, unless renewed.

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**STATUTORY PROVISIONS**

12. Section 4301 of the Code states:

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

...

(c) Gross negligence.

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

...

13. Section 4022 of the Code states

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

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

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

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

14. Section 4306.5 of the Code states in pertinent part, unprofessional conduct for a pharmacist may include any of the following:

(a) Acts or omissions that involve, in whole or in part, the inappropriate exercise of his or her education,

(b) Training, or experience as a pharmacist, whether or not the act or omission arises in the course of the practice of pharmacy or the ownership, management, administration, or operation of a pharmacy or other entity licensed by the Board

(c) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best

(d) 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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1 (e) Acts or omissions that involve, in whole or in part, the failure to consult  
2 appropriate patient, prescription, and other records pertaining to the performance  
3 of any pharmacy function

4 (f) Acts or omissions that involve, in whole or in part, the failure to fully maintain  
5 and retain appropriate patient specific information pertaining to the performance  
6 of any pharmacy function.

7 15. Health and Safety Code section 11152 states:

8 No Person shall write, issue, fill, compound, or dispense a prescription that does not  
9 conform to this division

10 16. Health and Safety Code section 11153 states in pertinent part:

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

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

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

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

26 No person shall prescribe a controlled substance, nor shall any person fill, compound, or  
27 dispense a prescription for a controlled substance, unless it complies with the requirement of this  
28 section.

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

(1) The prescription shall be signed and dated by the prescriber in ink

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1 **REGULATORY PROVISIONS**

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

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

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

10 **COST RECOVERY**

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

15 **DEFINITIONS**

16 20. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code  
17 section 11055, subdivision (b)(1)(M) and is a dangerous drug pursuant to Business and  
18 Professions Code section 4022. Oxycodone is a narcotic analgesic used for more moderate to  
19 severe pain and it has a high potential for abuse.

20 **FACTUAL ALLEGATIONS**

21 21. The Board initiated an investigation of Respondents based upon information that  
22 controlled substance prescriptions were dispensed by Respondent Pico, which may have not been  
23 in compliance with prescription security form requirements. Respondent Samouha was the owner  
24 of Century Pico Pharmacy. Respondents, Elahi, Azzizzadeh were employed as a pharmacist in  
25 charge at the pharmacy. Respondent Khani was employed as a pharmacist at the pharmacy.

26 22. The Board Inspector obtained and reviewed Respondent Pico's CURES records,  
27 dispensing records and original prescriptions documents.

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1 (d) Uniformity of treatment for multiple patients receiving similar or identical  
2 controlled substances;

3 (e) Multiple patients (up to ten a day) receiving identical or similar prescriptions on the  
4 same days.

5 30. Dr. Friedman's primary area of practice was not listed, but a secondary practice  
6 of pain management was listed. Prescription documents listed an address in Los Angeles.  
7 For Dr. Friedman, pharmacy records revealed:

8 (a) 21 of 21 patients were prescribed oxycodone;

9 (b) All oxycodone prescriptions were for 30 mg, the highest strength available;

10 (c) All controlled substance prescriptions were for cash payment;

11 (d) Uniformity of treatment for multiple patients receiving similar or identical  
12 controlled substances;

13 (e) Multiple patients (up to 5 a day) receiving identical or similar prescriptions on the  
14 same days.

15 31. Dr. Venkateswaralu's primary area of practice was listed as internal medicine.  
16 Prescription documents list an address in Los Angeles. For Dr. Venkateswarlu, pharmacy  
17 records revealed:

18 (a) 14 of 19 patients were prescribed oxycodone;

19 (b) All controlled substance prescription forms were invalid;

20 (c) All oxycodone prescriptions were for 30 mg, the highest strength available;

21 (d) All controlled substance prescriptions were for cash payment;

22 (e) Uniformity of treatment for multiple patients receiving similar or identical  
23 controlled substances;

24 (f) Multiple patients receiving identical or similar prescriptions on the same days.

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1 32. Dr. Korzelius primary area of practice is listed as general practice. Prescription  
2 documents dispensed under the name of Dr. Korzelius are believed to have been signed by  
3 PA Edwards. For Dr. Korzelius, pharmacy records revealed:

4 (a) 9 of 10 patients were prescribed oxycodone;

5 (b) All oxycodone prescriptions were for 30 mg, the highest strength available;

6 (c) All controlled substance prescriptions were for cash payment;

7 (d) Uniformity of treatment for multiple patients receiving similar or identical  
8 controlled substances;

9 (e) Multiple patients receiving identical or similar prescriptions on the same days.

10 **Respondent Elahi**

11 33. Respondent Elahi failed to use available records and information, and her education  
12 training, and experience, and best professional judgement, in the evaluation of controlled  
13 substance dispensing decisions when she personally approved for dispensing 129 oxycodone  
14 prescriptions with high starting doses.

15 **Respondent Khani**

16 34. Respondent Khani failed to use available records and information, and her education,  
17 training and experience, and best professional judgement, in evaluation of controlled substance  
18 dispensing decisions when she personally approved for dispensing 6 controlled substance  
19 prescriptions for 540 tablets of oxycodone 30 mg which had irregularities and red flags of  
20 illegitimacy.

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1 **FIRST CAUSE FOR DISCIPLINE**

2 (Unprofessional Conduct: Failure to Exercise Corresponding Responsibility)

3 (Against Respondent Pico, Respondent Elahi, Respondent Samouha, Respondent Azizzadeh and  
4 Respondent Khani.)

5 35. Respondent Pico, Respondent Elahi, Respondent Samouha, Respondent Azizzadeh  
6 and Respondent Khani are each and severally subject to disciplinary action under section 4301,  
7 subdivisions (c) and (d) and section 4306.5 of the Code, Health and Safety code section 11152,  
8 and section 11153, subdivision (a), and section 11164 subdivision (a)(1) and California Code of  
9 Regulations, title 16, section 1761, subdivisions (a) and (b), in that Respondents operated in a  
10 grossly negligent matter, which constituted unprofessional conduct, by excessively furnishing  
11 controlled substances, with an established history of a high potential abuse, despite multiple cues  
12 of irregularity and uncertainty related to patient and prescriber factors, and in failing to comply  
13 with their corresponding responsibility to ensure that controlled substances are dispensed for a  
14 legitimate medical purpose. Complainant refers to, and by this reference, incorporates the  
15 allegations set forth above in paragraphs 23-34, as though set forth fully.

16 **OTHER MATTERS**

17 36. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number  
18 PHY 41037 issued to Century Pico Pharmacy Inc., dba Century Pico Pharmacy Inc., while Joseph  
19 Amin has been an owner and had knowledge of or knowingly participated in any conduct for  
20 which the licensee was discipline, Joseph Amin, shall be prohibited from serving as a manager,  
21 administrator, owner, member, officer, director, associate, or partner of a licensee for five years if  
22 Pharmacy Permit Number PHY 41037 is placed on probation or until Pharmacy Permit Number  
23 PHY 41037 is reinstated if it is revoked.

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