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

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

**GLOVE WORK, INC., DBA CORBIN PHARMACY,**
**SCOTT KATZ, CHIEF EXECUTIVE OFFICER, 100% SHAREHOLDER,**
**DIRECTOR, SECRETARY AND CHIEF FINANCIAL OFFICER**
**Pharmacy Permit No. PHY 55733,**

**JANE HYUN HONG**
**Registered Pharmacist License No. RPH 70481,**

**and**

**MEHRNAZ AKHAVAN**
**Registered Pharmacist License No. RPH 40805**

**Respondents.**

**Agency Case No. 7076**

**OAH No. 2022020052**

# DECISION AND ORDER

The attached Stipulated Surrender of License and 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 August 30, 2023.

It is so ORDERED on July 31, 2023.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By 

Seung W. Oh, Pharm.D.
Board President

ROB BONTA
Attorney General of California
SHAWN P. COOK
Supervising Deputy Attorney General
VINODHINI RAMAGOPAL
Deputy Attorney General
State Bar No. 240534
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6270
Facsimile: (916) 731-2126
*Attorneys for Complainant*

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

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|---|---|
| In the Matter of the Accusation Against:<br><br>**GLOVE WORK, INC., DBA CORBIN PHARMACY**<br>**19664 Ventura Blvd.**<br>**Tarzana, CA 91356**<br><br>**SCOTT KATZ, Chief Executive Officer, 100% Shareholder, Director, Secretary and Chief Financial Officer**<br><br>**Pharmacy Permit No. PHY 55733,**<br><br>**JANE HYUN HONG**<br>**4143 Via Dolce #221**<br>**Marina Del Rey, CA 90292**<br><br>**Registered Pharmacist License No. RPH 70481**<br><br>**And**<br><br>**MEHRNAZ AKHAVAN**<br>**10600 Holman Ave., Apt. 1**<br>**Los Angeles, CA 90024**<br><br>**Registered Pharmacist License No. RPH 40805**<br><br>Respondents. | Case No. 7076<br><br>OAH No. 2022020052<br><br>**STIPULATED SURRENDER OF LICENSE AND ORDER AS TO JANE HYUN HONG ONLY** |

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

## PARTIES

1. Anne Sodergren (Complainant) is the Executive Officer of the Board of Pharmacy (Board). She brought this action solely in her official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Vinodhini Ramagopal, Deputy Attorney General.

2. Jane Hyun Hong (Respondent) is represented in this proceeding by attorney, Adam B. Brown, Esq., whose address is: 3848 W. Carson Street, Suite 206, Torrance, CA 90503.

3. On or about March 14, 2014, the Board of Pharmacy issued Registered Pharmacist License Number RPH 70481 to Respondent. The Registered Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2023, unless renewed.

## JURISDICTION

4. Accusation No. 7076 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on November 12, 2021. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 7076 is attached as Exhibit A and incorporated by reference.

## ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 7076. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

**CULPABILITY**

8. Respondent understands that the charges and allegations in Accusation No. 7076, if proven at a hearing, constitute cause for imposing discipline upon her Pharmacist License.

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

10. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Pharmacist License No. RPH 70481 without further process.

**CONTINGENCY**

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

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

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

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

**ORDER**

IT IS HEREBY ORDERED that Pharmacist License No. RPH 70481, issued to Respondent Jane Hyun Hong, is surrendered and accepted by the Board.

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

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

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a new application for licensure. Respondent must wait three years to reapply for any license from the Board. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 7076 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $10,000.00 prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 7076 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

**ACCEPTANCE**

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Adam B. Brown, Esq. I understand the stipulation and the effect it will have on my Pharmacist License. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: _____ _____

JANE HYUN HONG
*Respondent*

I have read and fully discussed with Respondent Jane Hyun Hong the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: _____ _____

ADAM B. BROWN, ESQ.
*Attorney for Respondent*

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6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 7076 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

**ACCEPTANCE**

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Adam B. Brown, Esq. I understand the stipulation and the effect it will have on my Pharmacist License. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 4/26/23

JANE HYUN HONG
*Respondent*

I have read and fully discussed with Respondent Jane Hyun Hong the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 4/26/23

ADAM B. BROWN, ESQ.
*Attorney for Respondent*

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## ENDORSEMENT

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

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
SHAWN P. COOK
Supervising Deputy Attorney General

VINODHINI RAMAGOPAL
Deputy Attorney General
*Attorneys for Complainant*

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**ENDORSEMENT**

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

DATED: April 27, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
SHAWN P. COOK
Supervising Deputy Attorney General

VINODHINI RAMAGOPAL
Deputy Attorney General
*Attorneys for Complainant*

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# Exhibit A

**Accusation No. 7076**

ROB BONTA
Attorney General of California
SHAWN P. COOK
Supervising Deputy Attorney General
VINODHINI RAMAGOPAL
Deputy Attorney General
State Bar No. 240534
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6270
Facsimile: (916) 731-2126
E-mail: Vinodhini.Ramagopal@doj.ca.gov
*Attorneys for Complainant*

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

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| In the Matter of the Accusation Against**:**<br><br>**GLOVE WORK, INC., DBA CORBIN PHARMACY**<br>**19664 Ventura Blvd.**<br>**Tarzana, CA 91356**<br><br>**SCOTT KATZ, Chief Executive Officer, 100% Shareholder, Director, Secretary and Chief Financial Officer**<br><br>**Pharmacy Permit No. PHY 55733,**<br><br>**JANE HYUN HONG**<br>**4143 Via Dolce #221**<br>**Marina Del Rey, CA 90292**<br><br>**Registered Pharmacist License No. RPH 70481**<br><br>**And**<br><br>**MEHRNAZ AKHAVAN**<br>**10600 Holman Ave., Apt. 1**<br>**Los Angeles, CA 90024**<br><br>**Registered Pharmacist License No. RPH 40805**<br><br>Respondents. | Case No. 7076<br><br>**FIRST AMENDED ACCUSATION** |

## PARTIES

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

2. On or about August 29, 2017, the Board of Pharmacy issued Pharmacy Permit Number PHY 55733 to Glove Work, Inc., dba Corbin Pharmacy (Respondent Pharmacy). Respondent Scott Katz (Respondent Katz) is and has been the Chief Executive Officer, 100% Shareholder, Director, Secretary and Chief Financial Officer since August 29, 2017. Jane Hyun Hong was the Pharmacist-in-Charge from May 24, 2018 to December 3, 2021. The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and expired on February 21, 2022.

3. On or about March 14, 2014, the Board of Pharmacy issued Registered Pharmacist License Number RPH 70481 to Respondent Jane Hyun Hong (Respondent Hong). The Registered Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2023, unless renewed.

4. On or about March 19, 1987, the Board of Pharmacy issued Registered Pharmacist License Number RPH 40805 to Respondent Mehrnaz Akhavan (Respondent Akhavan). The Registered Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2023, unless renewed.

## JURISDICTION

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

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

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7. Section 4307 of the Code states:

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

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

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

(b) "Manager, administrator, owner, member, officer, director, associate, partner, or any other person with management or control of a license" as used in this section and Section 4308, may refer to a pharmacist or to any other person who serves in such capacity in or for a licensee.

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

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## STATUTORY PROVISIONS

8. Section 4070 of the Code states in pertinent part:

(a) Except as provided in Section 4019 and subdivision (b), an oral or an electronic data transmission prescription as defined in subdivision (c) of Section 4040 shall as soon as practicable be reduced to writing by the pharmacist and shall be filled by, or under the direction of, the pharmacist. The pharmacist need not reduce to writing the address, telephone number, license classification, federal registry number of the prescriber or the address of the patient or patients if the information is readily retrievable in the pharmacy.

9. Section 4081, subdivision (a) of the Code states:

(a) All records of manufacture and of sale, acquisition, receipt, shipment, or disposition of dangerous drugs or dangerous devices shall be at all times during business hours open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept by every manufacturer, wholesaler, third-party logistics provider, pharmacy, veterinary food-animal drug retailer, outsourcing facility, physician, dentist, podiatrist, veterinarian, laboratory, licensed correctional clinic, as defined in Section 4187, clinic, hospital, institution, or establishment holding a currently valid and unrevoked certificate, license, permit, registration, or exemption under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 4 (commencing with Section 16000) of Division 9 of the Welfare and Institutions Code who maintains a stock of dangerous drugs or dangerous devices.

10. Section 4113 of the Code states in relevant part:

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

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

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

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

11. Section 4300 of the Code states:

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

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

(1) Suspending judgment.

(2) Placing him or her upon probation.

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

(4) Revoking his or her license.

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

(c) The board may refuse a license to any applicant guilty of unprofessional conduct. The board may, in its sole discretion, issue a probationary license to any applicant for a license who is guilty of unprofessional conduct and who has met all other requirements for licensure. The board may issue the license subject to any terms or conditions not contrary to public policy, including, but not limited to, the following:

(1) Medical or psychiatric evaluation.

(2) Continuing medical or psychiatric treatment.

(3) Restriction of type or circumstances of practice.

(4) Continuing participation in a board-approved rehabilitation program.

(5) Abstention from the use of alcohol or drugs.

(6) Random fluid testing for alcohol or drugs.

(7) Compliance with laws and regulations governing the practice of pharmacy.

(d) The board may initiate disciplinary proceedings to revoke or suspend any probationary certificate of licensure for any violation of the terms and conditions of probation. Upon satisfactory completion of probation, the board shall convert the probationary certificate to a regular certificate, free of conditions.

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

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:

(a) Procurement of a license by fraud or misrepresentation.

(b) Incompetence.

(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.

(e) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153.5 of the Health and Safety Code. Factors to be considered in determining whether the furnishing of controlled substances is clearly excessive shall include, but not be limited to, the amount of controlled substances furnished, the previous ordering pattern of the customer (including size and frequency of orders), the type and size of the customer, and where and to whom the customer distributes its product.

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

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

(h) The administering to oneself, of any controlled substance, or the use of any dangerous drug or of alcoholic beverages to the extent or in a manner as to be dangerous or injurious to oneself, to a person holding a license under this chapter, or to any other person or to the public, or to the extent that the use impairs the ability of the person to conduct with safety to the public the practice authorized by the license.

(i) Except as otherwise authorized by law, knowingly selling, furnishing, giving away, or administering, or offering to sell, furnish, give away, or administer, any controlled substance to an addict.

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

(k) The conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any dangerous drug or alcoholic beverage, or any combination of those substances.

(*l*) The conviction of a crime substantially related to the qualifications, functions, and duties of a licensee under this chapter. The record of conviction of a violation of Chapter 13 (commencing with Section 801) of Title 21 of the United States Code regulating controlled substances or of a violation of the statutes of this state regulating controlled substances or dangerous drugs shall be conclusive evidence of unprofessional conduct. In all other cases, the record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime, in order to fix the degree of discipline or, in the case of a conviction not involving controlled substances or dangerous drugs, to determine if the conviction is of an offense substantially related to the qualifications, functions, and duties of a licensee under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this provision. The board may take action when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(m) The cash compromise of a charge of violation of Chapter 13 (commencing with Section 801) of Title 21 of the United States Code regulating controlled substances or of Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code relating to the Medi-Cal program.

(n) The revocation, suspension, or other discipline by another state of a license to practice pharmacy, operate a pharmacy, or do any other act for which a license is required by this chapter that would be grounds for revocation, suspension, or other discipline under this chapter. Any disciplinary action taken by the board pursuant to this section shall be coterminous with action taken by another state, except that the term of any discipline taken by the board may exceed that of another state, consistent with the board's enforcement guidelines. The evidence of discipline by another state is conclusive proof of unprofessional conduct.

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

(p) Actions or conduct that would have warranted denial of a license.

(q) Engaging in any conduct that subverts or attempts to subvert an investigation of the board.

(r) The selling, trading, transferring, or furnishing of drugs obtained pursuant to Section 256b of Title 42 of the United States Code to any person a licensee knows or reasonably should have known, not to be a patient of a covered entity, as defined in paragraph (4) of subsection (a) of Section 256b of Title 42 of the United States Code.

(s) The clearly excessive furnishing of dangerous drugs by a wholesaler to a pharmacy that primarily or solely dispenses prescription drugs to patients of long-

term care facilities. Factors to be considered in determining whether the furnishing of dangerous drugs is clearly excessive shall include, but not be limited to, the amount of dangerous drugs furnished to a pharmacy that primarily or solely dispenses prescription drugs to patients of long-term care facilities, the previous ordering pattern of the pharmacy, and the general patient population to whom the pharmacy distributes the dangerous drugs. That a wholesaler has established, and employs, a tracking system that complies with the requirements of subdivision (b) of Section 4164 shall be considered in determining whether there has been a violation of this subdivision. This provision shall not be interpreted to require a wholesaler to obtain personal medical information or be authorized to permit a wholesaler to have access to personal medical information except as otherwise authorized by Section 56 and following of the Civil Code. For purposes of this section, long-term care facility shall have the same meaning given the term in Section 1418 of the Health and Safety Code.

13. Section 4306.5 of the Code states:

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

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

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

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

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

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

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

15. Health and Safety Code section 11167. 5 states in pertinent part:

(a) An order for a controlled substance classified in Schedule II for a patient of a licensed skilled nursing facility, a licensed intermediate care facility, a licensed home health agency, or a licensed hospice may be dispensed upon an oral or electronically transmitted prescription. If the prescription is transmitted orally, the pharmacist shall, prior to filling the prescription, reduce the prescription to writing in ink in the handwriting of the pharmacist on a form developed by the pharmacy for this purpose. If the prescription is transmitted electronically, the pharmacist shall, prior to filling the prescription, produce, sign, and date a hard copy prescription. The prescriptions shall contain the date the prescription was orally or electronically transmitted by the prescriber, the name of the person for whom the prescription was authorized, the name and address of the licensed skilled nursing facility, licensed intermediate care facility, licensed home health agency, or licensed hospice in which that person is a patient, the name and quantity of the controlled substance prescribed, the directions for use, and the name, address, category of professional licensure, license number, and federal controlled substance registration number of the prescriber. The original shall be properly endorsed by the pharmacist with the pharmacy's state license number, the name and address of the pharmacy, and the signature of the person who received the controlled substances for the licensed skilled nursing facility, licensed intermediate care facility, licensed home health agency, or licensed hospice. A licensed skilled nursing facility, a licensed intermediate care facility, a licensed home health agency, or a licensed hospice shall forward to the dispensing pharmacist a copy of any signed telephone orders, chart orders, or related documentation substantiating each oral or electronically transmitted prescription transaction under this section.

**REGULATORY PROVISIONS**

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

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

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

Pharmacists shall not deviate from the requirements of a prescription except upon the prior consent of the prescriber or to select the drug product in accordance with Section 4073 of the Business and Professions Code.

Nothing in this regulation is intended to prohibit a pharmacist from exercising commonly-accepted pharmaceutical practice in the compounding or dispensing of a prescription.

18. California Code of Regulations, title 16, section 1717, states:

(a) No medication shall be dispensed on prescription except in a new container which conforms with standards established in the official compendia.

Notwithstanding the above, a pharmacist may dispense and refill a prescription for non-liquid oral products in a clean multiple-drug patient medication package (patient med pak), provided:

(1) a patient med pak is reused only for the same patient;

(2) no more than a one-month supply is dispensed at one time; and

(3) each patient med pak bears an auxiliary label which reads, store in a cool, dry place.

(b) In addition to the requirements of Section 4040, Business and Professions Code, the following information shall be maintained for each prescription on file and shall be readily retrievable:

(1) The date dispensed, and the name or initials of the dispensing pharmacist. All prescriptions filled or refilled by an intern pharmacist must also be initialed by the supervising pharmacist before they are dispensed.

(2) The brand name of the drug or device; or if a generic drug or device is dispensed, the distributor's name which appears on the commercial package label; and

(3) If a prescription for a drug or device is refilled, a record of each refill, quantity dispensed, if different, and the initials or name of the dispensing pharmacist.

(4) A new prescription must be created if there is a change in the drug, strength, prescriber or directions for use, unless a complete record of all such changes is otherwise maintained.

(c) Promptly upon receipt of an orally transmitted prescription, the pharmacist shall reduce it to writing, and initial it, and identify it as an orally transmitted prescription. If the prescription is then dispensed by another pharmacist, the dispensing pharmacist shall also initial the prescription to identify him or herself.

All orally transmitted prescriptions shall be received and transcribed by a pharmacist prior to compounding, filling, dispensing, or furnishing.

Chart orders as defined in Section 4019 of the Business and Professions Code are not subject to the provisions of this subsection.

(d) A pharmacist may furnish a drug or device pursuant to a written or oral order from a prescriber licensed in a State other than California in accordance with Business and Professions Code Section 4005.

(e) A pharmacist may transfer a prescription for Schedule III, IV, or V controlled substances to another pharmacy for refill purposes in accordance with Title 21, Code of Federal Regulations, section 1306.26.

Prescriptions for other dangerous drugs which are not controlled substances may also be transferred by direct communication between pharmacists or by the receiving pharmacist=s access to prescriptions or electronic files that have been created or verified by a pharmacist at the transferring pharmacy. The receiving pharmacist shall create a written prescription; identifying it as a transferred prescription; and record the date of transfer and the original prescription number. When a prescription transfer is accomplished via direct access by the receiving pharmacist, the receiving pharmacist shall notify the transferring pharmacy of the transfer. A pharmacist at the transferring pharmacy shall then assure that there is a record of the prescription as having been transferred, and the date of transfer. Each pharmacy shall maintain inventory accountability and pharmacist accountability and

dispense in accordance with the provisions of section 1716 of this Division. Information maintained by each pharmacy shall at least include:

(1) Identification of pharmacist(s) transferring information;

(2) Name and identification code or address of the pharmacy from which the prescription was received or to which the prescription was transferred, as appropriate;

(3) Original date and last dispensing date;

(4) Number of refills and date originally authorized;

(5) Number of refills remaining but not dispensed;

(6) Number of refills transferred.

(f) The pharmacy must have written procedures that identify each individual pharmacist responsible for the filling of a prescription and a corresponding entry of information into an automated data processing system, or a manual record system, and the pharmacist shall create in his/her handwriting or through hand-initializing a record of such filling, not later than the beginning of the pharmacy's next operating day. Such record shall be maintained for at least three years.

19. California Code of Regulations, title 16, section 1718, states in relevant part:

"Current Inventory" as used in Sections 4081 and 4332 of the Business and Professions Code shall be considered to include complete accountability for all dangerous drugs handled by every licensee enumerated in Sections 4081 and 4332.

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

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

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

## COST RECOVERY

21. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

## DRUG CLASSIFICATIONS

| BRAND NAME | GENERIC NAME | DANGEROUS DRUG PER B&P 4022 | CONTROLLED SUBSTANCE PER H&S | INDICATIONS FOR USE |
|---|---|---|---|---|
| Norco/Lortab | Hydrocodone/acetaminophen (APAP) | Yes | Yes-Schedule II per H&S 11055(b)(1)(I)(ii) Yes-Scheduled II per Title CFR 1308.12 | Pain |
| Percolone/Roxicodone | Oxycodone | Yes | Yes-Scheduled II per H&S 11055(b)(1)(M) | Pain |
| Phenergan with Codeine Syrup | Promethazine/codeine syrup | Yes | Yes-Scheduled V per H&S 11058(c)(1) | Cough |
| Eliquis | Apixaban | Yes | No | Blood clots/stroke |
| Pepcid | Famotidine | Yes | No | Acid Reflux |
| Ozempic | Semaglutide | Yes | No | Diabetes |
| Pennsaid | Diclofenac Sodium | Yes | No | Topical non-steroidal anti-inflammatory |
| Farxiga | Dapagliflozin | Yes | No | Diabetes |
| Vascepa | Icosapent ethyl | Yes | No | High Triglycerides |
| Zegerid | Omeprazole/ Bicarbonate | Yes | No | Heartburn |
| Restasis | Cyclosporine | Yes | No | Dry Eye |
| Fluocinonide-E | Fluocinonide | Yes | No | Topical Steroid for Itch |

## FACTUAL ALLEGATIONS

22. At all times relevant herein, Scott Katz was the Chief Executive Officer, 100% Shareholder, Director, Secretary and Chief Financial Officer of Respondent Pharmacy – a

community pharmacy located in the city of Tarzana, CA. Respondent Hong was the Pharmacist-in-Charge of Respondent Pharmacy from May 24, 2018 to December 3, 2021. Respondent Akhavan was employed as a pharmacist with Respondent Pharmacy.

23. The Board performed a CURES[1] review and found that numerous controlled substance prescriptions were dispensed by Respondent Pharmacy. Said prescriptions were known to have patterns of red flags of abuse and illegitimacy.

24. The Board's investigation involved reviewing Respondent Pharmacy records and original prescription documents from August 29, 2017 through June 16, 2020. This review found a number of prescriptions having been dispensed with deviations from the prescribers' orders.

**MEDICATION ERRORS**

25. 2/23/2018 PRESCRIPTION ISSUED TO PATIENT KC

A. Patient KC was written a prescription for oxycodone 10/325 mg. Instead, Respondent Pharmacy dispensed oxycodone 30 mg. Additionally, on February 12, 2018 Respondent Pharmacy dispensed Patient KC 120 tablets of oxycodone 30 mg with directions to take one table every six hours, which would have been a 30-day supply. There was no documentation to justify dispensing another 90 tablets before the previous supply would have been exhausted. In response to the Board's investigation, Respondent Hong indicated that Patient KC was in hospice and the prescription was faxed in to be filled and the hard copy was received within 72 hours and that the pharmacist working at the time called the providers but did not transfer the information to the hard copy. Respondent Akhavan's responses to this investigation did not address the deviation from the prescriber's orders.

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[1] CURES is an acronym for "California Utilization Review and Evaluation System." It contains over 100 million entries of controlled substance drugs that were dispensed in California. Pharmacists and prescribers can register with the Department of Justice to obtain access to the CURES data through the California Prescription Drug Monitoring Program (PDMP). Patient Activity Reports (PARs) are provided and reflect all controlled substances dispensed to an individual. CURES herein refers to CURES in general and PARs. Pharmacies are required to report to the California Department of Justice every schedule II, II and IV drug prescription under Health and Safety Code section 11165, subdivision (d).

26. 7/17/2019 PRESCRIPTION ISSUED TO PATIENT SF

A. Patient SF was written a prescription for 120 tablets of oxycodone 30 mg to be taken every six hours. The notation on the prescription shows the prescriber approved the prescription to be changed to 240 tablets of oxycodone 15 mg. Respondent Pharmacy records indicate that 240 tablets of oxycodone 15 mg were dispensed, directing 1 tablet every 6 hours. Patient SF's dose was not lowered since the prescription was processed as a 30-day supply. There was no notation on the prescription document of prior prescriber consent to deviate from the directions prescribed. Respondent Akhavan's responses to this investigation did not address the deviation from the prescriber's orders.

27. 9/24/2019 PRESCRIPTION ISSUED TO PATIENT AK

A. Patient AK was written a prescription for 3 and ½ tablets daily of oxycodone 30 mg. Respondent Pharmacy records indicate that the dispensing directions provided were for 1 ½ tablets daily. Previously, Patient AK has been dispensed the same medication to be taken four times per day. There was no notation on the prescription document of prior prescriber consent to deviate from the directions prescribed or to clarify the unusual dosing prescribed. Respondent Akhavan's responses to this investigation did not address the deviation from the prescriber's orders.

28. 12/6/2019 PRESCRIPTION ISSUED TO PATIENT LJ

A. Patient LJ was written a prescription for oxycodone 30 mg with directions for 1 tablet 4 times per day. Respondent Pharmacy records indicate directions dispensed as 1 tablet twice per day. In response to this investigation, Respondents Hong and Akhavan indicated there was a verbal order phone in by the prescriber and that the original prescription provided directions to be take twice daily.

29. 1/16/2020 PRESCRIPTION ISSUED TO PATIENT SY

A. Patient SY was written a prescription for oxycodone 30 mg with directions for 1 tablet every 6 hours. Respondent Pharmacy dispensed directions for 1 tablet every 8 hours. There was no notation on the prescription document of prior prescriber consent to deviate from the directions prescribed. In response to this investigation, Respondent Hong stated this

prescription was mistyped. Respondent Akhavan's responses to this investigation did not address the deviation from the prescriber's orders.

30. 2/6/2020 PRESCRIPTION ISSUED TO PATIENT LJ

A. Patient LJ was written a prescription for oxycodone 30 mg with directions for 1 tablet 3 times per day. Respondent Pharmacy dispensed directions for 1 tablet twice per day. There was no notation on the prescription document of prior prescriber consent to deviate from the directions prescribed. In response to this investigation, Respondent Hong stated that this was a hospice patient for which the prescriber transmitted an oral prescription, which differed from the written prescription. Respondent Akhavan's responses to this investigation did not address the deviation from the prescriber's orders.

31. 2/13/2020 PRESCRIPTION ISSUED TO PATIENT FH

A. Patient FH was written a prescription for Oxycontin 30 mg but Respondent Pharmacy dispensed oxycodone 30 mg. There was no notation on the prescription document of prior prescriber consent to deviate from the drug prescribed. In response to this investigation, Respondents Hong and Akhavan provided a letter from the prescriber that stated the prescription should have been written for oxycodone instead of Oxycontin. Prior prescriber consent of the change of drug was not documented before dispensing nor did Respondent Pharmacy records identify the dispensing pharmacist.

32. 3/12/2020 PRESCRIPTION ISSUED TO PATIENT AA

A. Patient AA was written a prescription for oxycodone 30 mg with directions for 1 tablet 3 times per day. Respondent Pharmacy dispensed oxycodone 30 mg with inaccurate directions for 1 tablet 4 times per day. There was no notation on the prescription document of prior prescriber consent to deviate from the directions prescribed. In response to this investigation, Respondent Hong stated that this was a hospice patient for which the prescriber transmitted an oral prescription, which differed from the written prescription. Respondent Akhavan's responses to this investigation did not address the deviation from the prescriber's orders.

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33. 3/12/2020 PRESCRIPTION ISSUED TO PATIENT FN

A. Patient FN was written a prescription for oxycodone 30 mg with directions for 1 tablet 3 times per day. Respondent Pharmacy dispensed oxycodone 30 mg with inaccurate directions for 1 tablet twice per day. There was no notation on the prescription document of prior prescriber consent to deviate from the directions prescribed. In response to this investigation, Respondent Hong stated that this was a hospice patient for which the prescriber transmitted an oral prescription, which differed from the written prescription. Respondent Akhavan's responses to this investigation did not address the deviation from the prescriber's orders.

34. 3/20/2020 PRESCRIPTION ISSUED TO PATIENT BC

A. Patient BC was written a prescription for oxycodone 15 mg with directions for 4 tablets 4 times per day. Respondent Pharmacy dispensed oxycodone 15 mg with inaccurate directions for 1 tablet 3 times per day. Previously, this patient had been dispensed the same medication to be taken as one tablet (15 mg) 3 times per day. There was no notation on the prescription document of prior consent to deviate from the directions prescribed or to clarify the unusual dosage change. Respondent Akhavan's responses to this investigation did not address the deviation from the prescriber's orders.

**CORRESPONDING RESPONSIBILITY**

35. The Board's Inspector reviewed Respondent Pharmacy's dispensing data regarding both controlled and non-controlled prescriptions, a total of 117,745 prescriptions. The Board's Inspector found Respondent Pharmacy found oxycodone 30 mg to be in the top dozen most common drugs dispensed. The Board's Inspector reviewed Respondent Pharmacy's prescription records and determined the percentage of cash payments for controlled substances was over two to three times than non-controlled substances. In response, Respondent Hong stated that some insurances do not cover controlled substances and that the above issue could in part be due to billing a partial of the prescriptions as insurance and part as cash.

36. Regarding oxycodone prescriptions, the Board's Inspector found that Respondent Pharmacy dispensed 1,130 prescriptions of oxycodone 30 mg, a higher percentage (83.1%) compared to other lower strengths of oxycodone (5 mg, 10 mg, 15 mg, and 20 mg).

37. The Board's Inspector reviewed the top ten prescribers who wrote prescriptions for oxycodone 30 mg and who accounted for the majority of oxycodone 30 mg prescriptions dispensed by Respondent Pharmacy. Of the top ten prescribers, the Board's Inspector evaluated patterns of prescribing for four of them.

38. Pejman Shirazi, MD (Dr. Shirazi) is licensed by the California Medical Board as a physician and surgeon. Respondent Pharmacy's prescription documents revealed that oxycodone 30 mg was the most common controlled substance prescribed by Dr. Shirazi and dispensed by Respondent Pharmacy. The Board's Inspector further found that almost 95% of said oxycodone prescriptions were for the highest strength available, uniformity of treatment for multiple patients receiving similar or identical controlled substances, at times receiving identical or similar prescriptions on the same days, and at least nine patients not tolerant to opioids started, or restarted, on high oxycodone doses.

39. John Korzelius, MD (Dr. Korzelius) is licensed by the California Medical Board as a physician and surgeon. On August 5, 2020, the U.S. Department of Justice announced the arrest of Dr. Korzelius alleging his involvement in a narcotics trafficking ring that sold illegal opioid prescriptions for cash through a series of sham medical clinics. The Board's Inspector reviewed dispensing records provided by Respondent Pharmacy, which revealed 50 controlled substances dispensed pursuant to prescriptions from Dr. Korzelius. Of said 50 prescriptions, 96% were for cash and for oxycodone 30 mg. The Board's Inspector further found that almost 92% of oxycodone prescriptions were for the highest strength, uniformity of treatment for multiple patients receiving similar or identical controlled substances, at times receiving identical or similar prescriptions on the same days, and at least eleven patients not tolerant to opioids started, or restarted, on high oxycodone doses.

40. Jennifer M. Edwards, PA (PA Edwards) was licensed by the California Physician Assistant Board as a physician assistant. PA Edwards surrendered her Physician Assistant license with the Physician Assistant Board effective 08/23/2022 following a felony conviction after pleading guilty to one count of conspiracy to distribute and to possess with intent to distribute oxycodone on or about 06/01/2021. The Board's Inspector reviewed dispensing records and

prescription documents provided by Respondent Pharmacy. Regarding controlled substances dispensed, per prescriptions from PA Edwards, the Board's Inspector found high cash payment percentage for controlled substances, promethazine/codeine was the most common controlled substance dispensed, uniformity of treatment for some patients receiving similar or identical controlled substances, and at least three patients not tolerant to opioids started, or restarted, on high oxycodone doses.

41. Fariba Javaherian, MD (Dr. Javaherian) is licensed by the California Medical Board as a physician and surgeon. The Board's Inspector reviewed dispensing records and prescription documents provided by Respondent Pharmacy. Dr. Javaherian's primary areas of practice are listed as dermatology and internal medicine. The top controlled substance and most common drug, prescribed by Dr. Javaherian and dispensed by Respondent Pharmacy was oxycodone 30 mg. Regarding controlled substances dispensed, per prescriptions from Dr. Javaherian, the Board's Inspector found that almost all oxycodone prescriptions were for the highest strength available, uniformity of treatment for multiple patients receiving similar or identical controlled substances, sometimes receiving identical or similar prescriptions on the same days, very few prescriptions for hydrocodone/APAP, which is one of the most common drugs dispensed in the country and a common starting point for pain patients, and at least two patients not tolerant to opioids started, or restarted, on high oxycodone doses.

**HIGH STARTING DOSES OF OXYCODONE**

42. The Board's Inspector reviewed original prescriptions and found 38 instances in which Respondent Pharmacy dispensed oxycodone 30 mg to 35 different patients at dosages which were at least twice the recommended dose and without any documentation of effective intervention by a pharmacist.

**BOARD'S AUDIT FROM JANUARY 1, 2020 THROUGH JANUARY 24, 2022**

43. The Board received information from Prime Therapeutics indicating that Respondent Pharmacy had submitted prescription claims indicative of fraud, waste, and abuse.

44. The Board conducted an audit of Respondent Pharmacy regarding seven dangerous drugs from January 1, 2020 through January 24, 2022 based on information provided by

Respondent Pharmacy, Walgreens (Respondent Pharmacy had transferred all records to Walgreens after closing), and the drug wholesalers. The audit revealed the following:

(a) An overage of 547 Farxiga 10mg tablets;

(b) An overage of 11 Ozempic 1mg pens;

(c) An overage of 580 Eliquis 2.5 mg tablets;

(d) An overage of 881 Pennsaid 2% pump (112gm) bottles; and

(e) An overage of 3,191 Famotidine 40mg/5ml syrup 50ml bottles.

An overage indicates that Respondent Corbin processed prescriptions for more drug than they had purchased.

45. It was unlikely that Respondent Pharmacy had these large quantities in stock given their purchasing history from wholesaler, Cardinal. Specifically:

(a) Farxiga 10mg tablet: Respondent Pharmacy purchased one to two bottles at a time each costing $516.85 from Cardinal. An overage of 547 tablets would have been 18 bottles totaling $9,303.30 in inventory;

(b) Ozempic 1mg pen: Respondent Pharmacy purchased one or two pens at a time each costing $821.79 from Cardinal. An overage of 11 pens totaled $9,039.69 in inventory;

(c) Eliquis 2.5mg tablet: Respondent Pharmacy purchased one or two bottles at a time each costing $484.10 from Cardinal. An overage of 580 tablets would have been 9 bottles totaling $4,356.90;

(d) Pennsaid 2% pump (112gm) bottles: Respondent Pharmacy purchased four bottles at a time each costing $2,406.58 from Cardinal. An overage of 881 bottles totaled $2,120,196.90 in inventory; and

(e) Famotidine 40mg/5ml syrup 50ml bottles: Respondent Pharmacy purchased between 20 and 70 bottles at a time each costing $21.01 from Cardinal. An overage of 3,1919 bottles totaled $67,042.91 in inventory.

46. The Board's audit supported the information provided by Prime Therapeutics indicating that Respondent Pharmacy had dispensed more drug than they had purchased on five of the seven drugs audited.

47. During the course of its investigation, the Board learned that Respondent Pharmacy had filed a discontinuation of business on February 21, 2022, closed, and transferred all records to Walgreens. Also, Respondent Hong had left the company and ceased being the Pharmacist-In-Charge ("PIC") on December 3, 2021. Respondent Pharmacy did not have a designated PIC from December 3, 2021 to February 21, 2022.

**THE BOARD'S INVESTIGATION (2022)**

48. On or about June 21, 2022, the Board received information from Qlarant, a Medicare drug integrity contractor, related to possible fraud, waste, and abuse claims at Respondent Pharmacy. Qlarant had conducted audits on behalf of several insurance companies, including CVS Caremark and found that Respondent Pharmacy had failed to collect copayments for prescriptions, processed prescriptions with incorrect day supply causing prescription to be refilled too soon, and had medication shortages.

49. The Board received information from Qlarant based on the audits conducted. Specifically on or about January 27, 2020, CVS Caremark sent Respondent Pharmacy a list of the prescription discrepancies found from their initial prescription audit, which was conducted on October 15, 2017. CVS Caremark had found that twenty-three prescriptions refilled too soon and three prescriptions with insufficient directions. The Board confirmed the information provided by Qlarant based on the prescription documents provided by Respondent Pharmacy. For the prescriptions refilled too soon, the prescriptions were entered with the incorrect days' supply considering the directions and package size. This caused future refills to be processed too soon. The prescriptions filled with insufficient direction for use were entered as "apply to affected area" without specifying the area size and amount needed. See Table A:

| **Table A: Prescription Discrepancies Found by CVS Caremark** | | |
|---|---|---|
| *Refill Too Soon* | | |
| **Prescription #** | **Date of Refill** | **Drug Name** |
| 605690 | 5/15/2018 | Qvar Inh 80mcg |
| 607917 | 6/12/2018 | Lantus solo pen 100 u/ml |
| 604577 | 7/11/2018 | Symbicort Inh 160/4.5mcg |

| | | |
|---|---|---|
| 611369 | 9/6/2018 | Symbicort Inh 160/4.5mcg |
| 613664 | 9/28/2018 | Symbicort Inh 160/4.5mcg |
| 607688 | 8/2/2018 | Symbicort Inh 160/4.5mcg |
| 615388 | 11/1/2018 | Symbicort Inh 160/4.5mcg |
| 615902 | 12/28/2018 | Symbicort Inh 160/4.5mcg |
| 614910 | 11/16/2018 | Symbicort Inh 160/4.5mcg |
| 612369 | 10/3/2018 | Symbicort Inh 160/4.5mcg |
| 616803 | 11/29/2018 | Symbicort Inh 160/4.5mcg |
| 616792 | 11/27/2018 | Symbicort Inh 160/4.5mcg |
| 612497 | 10/9/2018<br>12/4/2018 | Qvar inh 80mcg |
| 619243 | 2/19/2019<br>4/22/2019 | Symbicort Inh 160/4.5mcg |
| 614910 | 1/15/2019 | Symbicort Inh 160/4.5mcg |
| 616792 | 2/4/2019<br>4/9/2019 | Symbicort Inh 160/4.5mcg |
| 617146 | 2/19/2019<br>4/9/2019 | Qvar inh 80mcg |
| 616638 | 2/19/2019 | Qvar inh 80mcg |
| 624300 | 4/23/2019 | Qvar inh 80mcg |
| *Insufficient Directions for Use* | | |
| 619088 | 2/20/2019<br>3/18/2019<br>4/11/2019 | Clobetasol oint 0.05% |

50. Additionally, based on the information received from Qlarant, Respondent Pharmacy failed to provide proof of co-payment collections for twenty-three prescriptions. See Table B:

| **Table B: Co-Payment Not Collected** | | |
|---|---|---|
| **Prescription #** | **Date of Refill** | **Drug Name** |
| 664618 | 2/5/2021 | Doxepin 5% cream |
| 664699 | 1/21/2021<br>2/19/2021 | Omeprazole/Bicarbonate 40mg/1680mg |
| 665009 | 11/2/2020 | Lidoderm 5% patch |
| 666003 | 9/14/202<br>1/7/2021 | Famotidine 40mg/5ml suspension |
| 668117 | 10/5/2020<br>2/8/2021 | Famotidine 40mg/5ml suspension |
| 668676 | 10/12/2020 | Famotidine 40mg/5ml suspension |
| 669747 | 10/22/2020 | Famotidine 40mg/5ml suspension |

| | | |
|---|---|---|
| 670210 | 10/27/2020 | Famotidine 40mg/5ml suspension |
| 673306 | 1/8/2021 | Famotidine 40mg/5ml suspension |
| 674376 | 12/7/2020<br>12/22/2020 | Famotidine 40mg/5ml suspension |
| 674506 | 12/20/2020 | Lidoderm 5% patch |
| 676131 | 12/25/2020<br>1/26/2021<br>2/24/2021 | Famotidine 40mg/5ml suspension |
| 678494 | 1/22/2021<br>3/4/2021<br>4/5/2021 | Famotidine 40mg/5ml suspension |
| 678576 | 1/22/2021 | Famotidine 40mg/5ml suspension |
| 680487 | 2/12/2021 | Famotidine 40mg/5ml suspension |
| 682580 | 3/5/2021 | Omeprazole/Bicarbonate 40mg/1680mg |
| 683896 | 3/19/2021 | Omeprazole/Bicarbonate 40mg/1680mg |
| 684443 | 3/30/2021<br>4/24/2021 | Omeprazole/Bicarbonate 40mg/1680mg |
| 684502 | 3/25/2021<br>4/22/2021<br>5/24/2021 | Famotidine 40mg/5ml suspension |
| 684855 | 5/13/2021 | Omeprazole/Bicarbonate 40mg/1680mg |
| 686031 | 5/12/2021 | Lidoderm 5% patch |
| 689178 | 5/12/2021 | Omeprazole/Bicarbonate 40mg/1680mg |
| 689561 | 5/14/2021 | Famotidine 40mg/5ml suspension |

51. An audit of Respondent Pharmacy between May 1, 2020 and May 31, 2020, by CVS Caremark of 50 drugs, resulted in 20 drug shortages. Respondent Pharmacy was terminated from the CVC Caremark network when they discontinued business on February 14, 2022.

52. The Board conducted an audit of Respondent Pharmacy regarding from January 1, 2020 through January 24, 2022 based on information provided by Respondent Pharmacy, Walgreens (Respondent Pharmacy had transferred all records to Walgreens after closing), and the drug wholesalers. The audit resulted in overages of:

(a) An overage of 28,895 capsules of Vascepa 1gm;

(b) An overage of 26,400 grams of fluocinonide 0.1% cream;

(c) An overage of 16,260 vials of Restasis 0.4ml;

(d) An overage of 18 vials of Restasis 5.5ml multi-dose vials; and

(e) An overage of 10,470 packets of Omeprazole/Bicarbonate 40mg/1680mg.

An overage indicates that Respondent Corbin dispensed more drug than they had purchased for each drug demonstrating insurance fraud.

53. Based on the purchase prices provided by the wholesaler, the total purchases not made by Respondent Pharmacy for the drugs audited are:

(a) Vascepa 1gm: 120 capsules cost $321.05. An overage of 28,895 capsules is $77,306.16 worth of inventory never purchased;

(b) Fluocinonide 0.1% cream: a 120gm tube cost $21.01. An overage of 26,400 grams is $4,622.20 worth of inventory never purchased;

(c) Restasis 0.4ml vials: 60 vials cost $593.37. An overage of 16,260 vials is $160,803.27 worth of inventory never purchased;

(d) Restasis 5.5ml multi-dose vials: One vial cost $596.44. An overage of 18 vials is $10,735.92 of inventory never purchased; and

(e) Omeprazole/bicarbonate 40mg/1680mg packets: 30 packets cost $359.91. An overage of 10,470 packets is $125,608.59 worth of inventory never purchased.

Respondent Pharmacy failed to purchase $379,076.14 worth of inventory to cover prescription claims for the five drugs audited.

**FIRST CAUSE FOR DISCIPLINE**

(Variation from Prescription)

54. Respondent Pharmacy is subject to disciplinary action pursuant to Code section 4301, subdivision (j) and/or (o) in conjunction with California Code of Regulations section 1716, in conjunction with Health and Safety Code section 11167.5, based on evidence reviewed by a Board Inspector, Respondent dispensed prescriptions which deviated prescribers' orders and failed to document verbal order prescriptions for hospice patients. The allegations of paragraphs 22 through 42 above are realleged as though fully set forth.

**SECOND CAUSE FOR DISCIPLINE**

(Unprofessional Conduct- Failed to Comply with Corresponding Responsibility Requirements)

55. Respondent Pharmacy is subject to discipline pursuant to Code section 4300 for unprofessional conduct as defined in section 4301, subdivisions (d), (j), and (o), in conjunction with Health and Safety Code section 11153(a) based on evidence reviewed by a Board Inspector, Respondent failed to meet its corresponding responsibility to assure legitimate prescriptions, in that Respondent ignored and/or failed to appropriately respond to numerous warning signs or red flags that should put a reasonable and prudent dispensing pharmacist on notice that prescriptions for patients may not have been legitimate. The allegations of paragraphs 22 through 42 above are realleged as though fully set forth.

**THIRD CAUSE FOR DISCIPLINE**

(Variation from Prescription)

56. Respondent Hong is subject to disciplinary action pursuant to Code section 4301, subdivision (j) and/or (o) in conjunction with California Code of Regulations section 1716, in conjunction with Health and Safety Code section 11167.5, based on evidence reviewed by a Board Inspector, Respondent dispensed prescriptions which deviated from prescribers' orders and failed to document verbal order prescriptions for hospice patients. The allegations of paragraphs 22 through 42 above are realleged as though fully set forth.

**FOURTH CAUSE FOR DISCIPLINE**

(Unprofessional Conduct Failed to Comply with Corresponding Responsibility Requirements)

57. Respondent Hong is subject to discipline pursuant to Code section 4300 for unprofessional conduct as defined in section 4301, subdivisions (d), (j), and (o), in conjunction with Health and Safety Code section 11153(a) based on evidence reviewed by a Board Inspector, Respondent failed to meet her corresponding responsibility to assure legitimate prescriptions, in that Respondent ignored and/or failed to appropriately respond to numerous warning signs or red flags that should put a reasonable and prudent dispensing pharmacist on notice that prescriptions for patients may not have been legitimate. The allegations of paragraphs 22 through 42 above are realleged as though fully set forth.

**FIFTH CAUSE FOR DISCIPLINE**

(Gross Negligence)

58. Respondent Hong is subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivision (c) in that Respondent Hong committed gross negligence in her practice as a pharmacist, her acts and/or omissions which were an extreme departure from the standard of care, which under similar circumstances, would have been ordinarily exercised by a competent pharmacist. The allegations of paragraphs 22 through 42 above are realleged as though fully set forth.

**SIXTH CAUSE FOR DISCIPLINE**

(Unprofessional Conduct)

59. Respondent Hong is subject to discipline pursuant to Code section 4300 for unprofessional conduct as defined in section 4301, and section 4306.5, in that Respondent's acts or omissions involve, in whole or in part, the inappropriate exercise of his education, training, or experience as a pharmacist, in that Respondent ignored and/or failed to appropriately respond to numerous warning signs or red flags that should put a reasonable and prudent dispensing pharmacist on notice that prescriptions for patients may not have been legitimate. The allegations of paragraphs 22 through 42 above are realleged as though fully set forth.

**SEVENTH CAUSE FOR DISCIPLINE**

(Unprofessional Conduct Failed to Comply with Corresponding Responsibility Requirements)

60. Respondent Akhavan is subject to discipline pursuant to Code section 4300 for unprofessional conduct as defined in section 4301, subdivisions (d), (j), and (o), in conjunction with Health and Safety Code section 11153(a) based on evidence reviewed by a Board Inspector, Respondent failed to meet her corresponding responsibility to assure legitimate prescriptions, in that Respondent ignored and/or failed to appropriately respond to numerous warning signs or red flags that should put a reasonable and prudent dispensing pharmacist on notice that prescriptions for patients may not have been legitimate. The allegations of paragraphs 22 through 42 above are realleged as though fully set forth.

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**EIGHTH CAUSE FOR DISCIPLINE**

(Failure to Timely Notify the Board of a New Pharmacist-In-Charge)

61. Respondent Pharmacy is subject to disciplinary action pursuant to Code section 4113, subdivision (d) in that Respondent Pharmacy failed to report a new PIC to the Board within 30 days as required. Specifically, Respondent Hong ceased to act as the PIC on December 3, 2021 and Respondent Pharmacy did not designate a new PIC within 30 days. Respondent Pharmacy filed a discontinuation of business on February 21, 2022 and failed to designated a PIC from December 3, 2021 to February 21, 2022. The allegations of paragraphs 43 through 46 above are realleged as though fully set forth.

**NINTH CAUSE FOR DISCIPLINE**

(Failure to Maintain Accountability of Dangerous Drugs)

62. Respondent Pharmacy is subject to disciplinary action pursuant to Code sections 4081, subdivision (a), section 4301, subdivision (j) and/or (o), in conjunction with California Code of Regulations, title 16, section 1718 in that that Respondent Pharmacy failed to maintain complete accountability of all dangerous drugs. Specifically, an audit of dangerous drugs from January 1, 2020 through January 24, 2022 revealed overages of 547 Farxiga 10mg tablets, 11 Ozempic 1mg pens, 580 Eliquis 2.5mg tablets, 881 Pennsaid 2% pump (112gm) bottles, and 3,191 Famotidine 40mg/5ml 50ml bottles. These overages indicated Respondent Pharmacy had processed prescriptions for more drug than they had purchased failing to purchase approximately $2,209,939.70 worth of inventory. The allegations of paragraphs 43 through 46 above are realleged as though fully set forth.

**TENTH CAUSE FOR DISCIPLINE**

(Unprofessional Conduct: Failure to Maintain, Secure, and Distribute Dangerous Drugs)

63. Respondent Pharmacy is subject to disciplinary action pursuant to Code section 4301, subdivision (j) and/or (o) in conjunction with California Code of Regulations, title 16, section 1714, subdivision (b) in that Respondent Pharmacy failed to properly maintain, secure, and distribute dangerous drugs. Specifically, an audit of dangerous drugs from January 1, 2020 through January 24, 2022 revealed overages of 547 Farxiga 10mg tablets, 11 Ozempic 1mg pens,

580 Eliquis 2.5mg tablets, 881 Pennsaid 2% pump (112gm) bottles, and 3,191 Famotidine 40mg/5ml 50ml bottles. These overages indicated Respondent Pharmacy had processed prescriptions for more drug than they had purchased failing to purchase approximately $2,209,939.70 worth of inventory. The allegations of paragraphs 43 through 46 above are realleged as though fully set forth.

**ELEVENTH CAUSE FOR DISCIPLINE**

(Unprofessional Conduct: Dishonesty and Fraud)

64. Respondent Pharmacy is subject to disciplinary action pursuant to Code section 4301, subdivision (f) for unprofessional conduct in that Respondent Pharmacy processed prescriptions for more drug than they had purchased, which is indicative of dishonesty and fraud. Specifically, an audit of dangerous drugs from January 1, 2020 through January 24, 2022 revealed overages of 547 Farxiga 10mg tablets, 11 Ozempic 1mg pens, 580 Eliquis 2.5mg tablets, 881 Pennsaid 2% pump (112gm) bottles, and 3,191 Famotidine 40mg/5ml 50ml bottles. These overages indicated Respondent Pharmacy had processed prescriptions for more drug than they had purchased failing to purchase approximately $2,209,939.70 worth of inventory. The allegations of paragraphs 43 through 46 above are realleged as though fully set forth.

**TWELFTH CAUSE FOR DISCIPLINE**

(Failure to Maintain Accountability of Dangerous Drugs)

65. Respondent Hong is subject to disciplinary action pursuant to Code sections 4081, subdivision (a), section 4301, subdivision (j) and/or (o), and section 4113, subdivision (c) in conjunction with California Code of Regulations, title 16, section 1718 in that Respondent Hong, as the PIC of Respondent Pharmacy from May 24, 2018 to December 3, 2021, failed to maintain complete accountability of all dangerous drugs. Specifically, an audit of dangerous drugs from January 1, 2020 through January 24, 2022 revealed overages of 547 Farxiga 10mg tablets, 11 Ozempic 1mg pens, 580 Eliquis 2.5mg tablets, 881 Pennsaid 2% pump (112gm) bottles, and 3,191 Famotidine 40mg/5ml 50ml bottles. These overages indicated Respondent Pharmacy had processed prescriptions for more drug than they had purchased and failed to purchase

approximately $2,209,939.70 worth of inventory. The allegations of paragraphs 43 through 46 above are realleged as though fully set forth.

**THIRTEENTH CAUSE FOR DISCIPLINE**

(Unprofessional Conduct: Failure to Maintain, Secure, and Distribute Dangerous Drugs)

66. Respondent Hong is subject to disciplinary action pursuant to Code section 4301, subdivision (j) and/or (o), and section 4113, subdivision (c) in conjunction with California Code of Regulations, title 16, section 1714, subdivision (b) in that Respondent Hong, as the PIC of Respondent Pharmacy from May 24, 2018 to December 3, 2021, failed to properly maintain, secure, and distribute dangerous drugs. Specifically, an audit of dangerous drugs from January 1, 2020 through January 24, 2022 revealed overages of 547 Farxiga 10mg tablets, 11 Ozempic 1mg pens, 580 Eliquis 2.5mg tablets, 881 Pennsaid 2% pump (112gm) bottles, and 3,191 Famotidine 40mg/5ml 50ml bottles. These overages indicated Respondent Pharmacy had processed prescriptions for more drug than they had purchased failing to purchase approximately $2,209,939.70 worth of inventory. The allegations of paragraphs 43 through 46 above are realleged as though fully set forth.

**FOURTEENTH CAUSE FOR DISCIPLINE**

(Unprofessional Conduct: Dishonesty and Fraud)

67. Respondent Hong is subject to disciplinary action pursuant to Code section 4301, subdivision (f) and section 4113, subdivision (c) for unprofessional conduct in that Respondent Hong, as the PIC of Respondent Pharmacy from May 24, 2018 to December 3, 2021, processed prescriptions for more drug than they had purchased, which is indicative of dishonesty and fraud. Specifically, an audit of dangerous drugs from January 1, 2020 through January 24, 2022 revealed overages of 547 Farxiga 10mg tablets, 11 Ozempic 1mg pens, 580 Eliquis 2.5mg tablets, 881 Pennsaid 2% pump (112gm) bottles, and 3,191 Famotidine 40mg/5ml 50ml bottles. These overages indicated Respondent Pharmacy had processed prescriptions for more drug than they had purchased failing to purchase approximately $2,209,939.70 worth of inventory. The allegations of paragraphs 43 through 46 above are realleged as though fully set forth.

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**FIFTEENTH CAUSE FOR DISCIPLINE**

(Failure to Maintain Accountability and Records of Dangerous Drugs)

68. Respondent Pharmacy is subject to disciplinary action pursuant to Code sections 4081, subdivision (a), section 4301, subdivision (j) and/or (o), in conjunction with California Code of Regulations, title 16, section 1718 in that that Respondent Pharmacy failed to maintain complete accountability of all dangerous drugs. Specifically, an audit of dangerous drugs from January 1, 2020 through January 24, 2022 revealed overages of 28,895 capsules of Vascepa 1gm; 26,400 grams of fluocinonide 0.1% cream; 16,260 vials of Restasis 0.4ml; 18 vials of Restasis 5.5ml multi-dose; and 10,470 packets of Omeprazole/Bicarbonate 40mg/1680mg. These overages indicated Respondent Pharmacy had processed prescriptions for more drug than they had purchased and failed to purchase approximately $379,076.14 worth of inventory. The allegations of paragraphs 48 through 53 above are realleged as though fully set forth.

**SIXTEENTH CAUSE FOR DISCIPLINE**

(Unprofessional Conduct: Failure to Maintain, Secure, and Distribute Dangerous Drugs)

69. Respondent Pharmacy is subject to disciplinary action pursuant to Code section 4301, subdivision (j) and/or (o) in conjunction with California Code of Regulations, title 16, section 1714, subdivision (b) in that Respondent Pharmacy failed to distribute dangerous drugs. Specifically, an audit of dangerous drugs from January 1, 2020 through January 24, 2022 revealed overages of 28,895 capsules of Vascepa 1gm; 26,400 grams of fluocinonide 0.1% cream; 16,260 vials of Restasis 0.4ml; 18 vials of Restasis 5.5ml multi-dose; and 10,470 packets of Omeprazole/Bicarbonate 40mg/1680mg. These overages indicated Respondent Pharmacy had processed prescriptions for more drug than they had purchased and failed to purchase approximately $379,076.14 worth of inventory. The allegations of paragraphs 48 through 53 above are realleged as though fully set forth.

**SEVENTEENTH CAUSE FOR DISCIPLINE**

(Unprofessional Conduct: Dishonesty and Fraud)

70. Respondent Pharmacy is subject to disciplinary action pursuant to Code section 4301, subdivision (f) for unprofessional conduct in that Respondent Pharmacy processed prescriptions

for more drug than they had purchased, which is indicative of dishonesty and fraud. Specifically, an audit of dangerous drugs from January 1, 2020 through January 24, 2022 revealed overages of 28,895 capsules of Vascepa 1gm; 26,400 grams of fluocinonide 0.1% cream; 16,260 vials of Restasis 0.4ml; 18 vials of Restasis 5.5ml multi-dose; and 10,470 packets of Omeprazole/Bicarbonate 40mg/1680mg. These overages indicated Respondent Pharmacy had processed prescriptions for more drug than they had purchased and failed to purchase approximately $379,076.14 worth of inventory. Additionally, Respondent Pharmacy incorrectly processed prescriptions with the wrong day supply causing future refills to be too soon to fill and insufficient directions for use as summarized in Table A, paragraph 47. Also, Respondent Pharmacy failed to provide proof of copayment collection for prescriptions as summarized in Table B, paragraph 48. The allegations of paragraphs 48 through 53 above are realleged as though fully set forth.

**EIGHTEENTH CAUSE FOR DISCIPLINE**

(Failure to Maintain Accountability and Records of Dangerous Drugs)

71. Respondent Hong is subject to disciplinary action pursuant to Code sections 4081, subdivision (a), section 4301, subdivision (j) and/or (o), and section 4113, subdivision (c) in conjunction with California Code of Regulations, title 16, section 1718 in that Respondent Hong, as the PIC of Respondent Pharmacy from May 24, 2018 to December 3, 2021, failed to maintain complete accountability of all dangerous drugs. Specifically, an audit of dangerous drugs from January 1, 2020 through January 24, 2022 revealed overages of 28,895 capsules of Vascepa 1gm; 26,400 grams of fluocinonide 0.1% cream; 16,260 vials of Restasis 0.4ml; 18 vials of Restasis 5.5ml multi-dose; and 10,470 packets of Omeprazole/Bicarbonate 40mg/1680mg. These overages indicated Respondent Pharmacy had processed prescriptions for more drug than they had purchased and failed to purchase approximately $379,076.14 worth of inventory. The allegations of paragraphs 48 through 53 above are realleged as though fully set forth.

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**NINETEENTH CAUSE FOR DISCIPLINE**

(Unprofessional Conduct: Failure to Maintain, Secure, and Distribute Dangerous Drugs)

72. Respondent Hong is subject to disciplinary action pursuant to Code section 4301, subdivision (j) and/or (o), and section 4113, subdivision (c) in conjunction with California Code of Regulations, title 16, section 1714, subdivision (b) in that Respondent Hong, as the PIC of Respondent Pharmacy from May 24, 2018 to December 3, 2021, failed to properly distribute dangerous drugs. Specifically, an audit of dangerous drugs from January 1, 2020 through January 24, 2022 revealed overages of 28,895 capsules of Vascepa 1gm; 26,400 grams of fluocinonide 0.1% cream; 16,260 vials of Restasis 0.4ml; 18 vials of Restasis 5.5ml multi-dose; and 10,470 packets of Omeprazole/Bicarbonate 40mg/1680mg. These overages indicated Respondent Pharmacy had processed prescriptions for more drug than they had purchased and failed to purchase approximately $379,076.14 worth of inventory. The allegations of paragraphs 48 through 53 above are realleged as though fully set forth.

**TWENTIETH CAUSE FOR DISCIPLINE**

(Unprofessional Conduct: Dishonesty and Fraud)

73. Respondent Hong is subject to disciplinary action pursuant to Code section 4301, subdivision (f) and section 4113, subdivision (c) for unprofessional conduct in that Respondent Hong, as the PIC of Respondent Pharmacy from May 24, 2018 to December 3, 2021, failed to collect prescription copayments, process prescriptions with the correct day supply and sufficient directions, and processed prescriptions for more drug than they had purchased, which is indicative of dishonesty and fraud. Specifically, an audit of dangerous drugs from January 1, 2020 through January 24, 2022 revealed overages of 28,895 capsules of Vascepa 1gm; 26,400 grams of fluocinonide 0.1% cream; 16,260 vials of Restasis 0.4ml; 18 vials of Restasis 5.5ml multi-dose; and 10,470 packets of Omeprazole/Bicarbonate 40mg/1680mg. These overages indicated Respondent Pharmacy had processed prescriptions for more drug than they had purchased and failed to purchase approximately $379,076.14 worth of inventory. Additionally, Respondent Pharmacy incorrectly processed prescriptions with the wrong day supply causing future refills to be too soon to fill and insufficient directions for use as summarized in Table A, paragraph 49.

Also, Respondent Pharmacy failed to provide proof of copayment collection for prescriptions as summarized in Table B, paragraph 50. The allegations of paragraphs 48 through 53 above are realleged as though fully set forth.

**DISCIPLINARY CONSIDERATIONS**

74. To determine the degree of penalty to be imposed on Respondent(s), if any, Complainant makes the following additional allegations:

A. Prior Citation (Respondent Akhavan) - On or about January 25, 2017, Administrative Citation/Assessment of Fine No. **CI 2016 73680** was issued to Respondent Akhavan for violating Codes and Regulations as set forth below. The citation is now final.

| Code/Regulation(s) Violated | Offense |
|---|---|
| CA Code of Regulations (CCR), title 16, § 1714 subd. (d) | Operational Standards and Security; Pharmacist responsible for pharmacy security |

B. Prior Citation (Respondent Akhavan) - On or about October 1, 2019, Administrative Citation/Assessment of Fine No. **CI 2018 84712** was issued to Respondent Akhavan for violating Codes and Regulations as set forth below, resulting in the issuance of a $3,500.00 fine. The citation is now final.

| Code/Regulation(s) Violated | Offense | Amount of Fine |
|---|---|---|
| Health & Safety Code § 11164 subd. (a)/Health & Safety Code § 11162.1 subd. (a)(2)(10)(13)/11162.1(b) | 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/Prescription forms for Controlled Substances; (2) A watermark "California Security Prescription" shall be printed on the backside of the prescription; (10) Check boxes shall be printed on the form so that the prescriber may indicate the number of refills ordered; (13) An identifying number assigned to the approved security printer by the Department of Justice/(b) Each batch of controlled substance prescription forms shall have the lot number printed on the form | $2,000 |

| | | |
|---|---|---|
| Bus. & Prof. Code § 4081 subd. (a)/Bus. & Prof. Code § 4105 subd. (a) & (c)/ Bus. & Prof. Code § 4169 subd. (a)/Bus. & Prof. Code § 4333 subd. (a) | Records of Dangerous Drugs and Devices Kept Open for Inspection; Maintenance of Records, Current Inventory/Retaining Records of Dangerous Drugs and Devices on Licensed Premises; All records shall be retained on the licensed premises in a readily retrievable form/for a period of three years from the date of making/Prohibited Acts; Purchase, trade, sell, or transfer dangerous drugs to unlicensed person or entity…/Maintaining prescriptions on the premises for at least three years | $500 |
| CA Code of Regulations (CCR), title 16, § 1717 subd. (b) | Information shall be maintained for each prescription on file and readily retrievable | $1,000 |

**OTHER MATTERS**

75. Section 4307 of the Code states:

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

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

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

(b) "Manager, administrator, owner, member, officer, director, associate, partner, or any other person with management or control of a license" as used in this section and Section 4308, may refer to a pharmacist or to any other person who serves in such capacity in or for a licensee.

76. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 55733 issued to Glove Work, Inc., dba Corbin Pharmacy, then Glove Work, Inc., dba Corbin Pharmacy shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 55733 is placed on probation or until Pharmacy Permit Number PHY 55733 is revoked.

77. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 55733 issued to Glove Work, Inc., dba Corbin Pharmacy, if Respondent Katz had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, then Respondent Katz shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 55733 is placed on probation or until Pharmacy Permit Number PHY 55733 is reinstated if it is revoked.

78. Pursuant to Code section 4307, if disciplined is imposed on Pharmacist License Number RPH 70481 issued to Respondent Jane Hyun Hong, then she shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 70481 is placed on probation or until Pharmacist License Number RPH 70481 is reinstated if it is revoked.

79. Pursuant to Code section 4307, if disciplined is imposed on Pharmacist License Number RPH 40805 issued to Respondent Mehrnaz Akhavan, then she shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 40805 is placed on probation or until Pharmacist License Number RPH 40805 is reinstated if it is revoked.

## PRAYER

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

1. Revoking or suspending Pharmacy Permit Number PHY 55733, issued to Glove Work, Inc., dba Corbin Pharmacy;

2. Revoking or suspending Registered Pharmacist License Number RPH 70481, issued to Jane Hyun Hong;

3. Revoking or suspending Registered Pharmacist License Number RPH 40805, issued to Mehrnaz Akhavan;

4. Prohibiting Glove Work, Inc., dba Corbin Pharmacy from serving as a manager, Administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 55733 is placed on probation or until Pharmacy Permit Number PHY 55733 is reinstated if Pharmacy Permit Number PHY 55733 issued to Glove Work, Inc., dba Corbin Pharmacy is revoked;

5. Prohibiting Scott Katz from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 55733 is placed on probation or until Pharmacy Permit Number PHY 55733 is reinstated if Pharmacy Permit Number PHY 55733 issued to Glove Work, Inc., dba Corbin Pharmacy is revoked;

6. Prohibiting Jane Hyun Hong from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 70481 is placed on probation or until Pharmacist License Number RPH 70481 is reinstated if it is revoked.

7. Prohibiting Mehrnaz Akhavan from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 40805 is placed on probation or until Pharmacist License Number RPH 40805 is reinstated if it is revoked.

8. Ordering Glove Work, Inc., dba Corbin Pharmacy, Scott Katz, Jane Hyun Hong and Mehrnaz Akhavan to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

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

DATED: 2/24/2023

Sodergren, Anne@DCA

Digitally signed by Sodergren, Anne@DCA
Date: 2023.02.24 13:33:04 -08'00'

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

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