**The Actual Public Comment for Board of Pharmacy Meeting 6/23/2026 Requesting Auxiliary Labeling Improvements**

My name is Stephen Rosati and I am a pharmacist from Hollister. I'm here today to urge the Board to address a critical safety gap regarding auxiliary labeling for prescription labels. I am making these comments not only from a healthcare provider's point of view but as a consumer as I am now obtaining my prescriptions from pharmacies other than where I worked in the past.

In 2009 the Board of Pharmacy made incredible strides in patient safety through establishing the Patient Centered Label Improvements to Title 16, Section 1707.5 that took place during all the time dedicated to the planning, input, public hearings and re-amending that resulted. Today, patients can easily read their names, names & strengths of medications and directions for use in a mandated 12-point, easily readable font. However, the vital safety warnings on **auxiliary labeling** — like *'Take with Food', 'Do Not Drive,' 'Finish All Medication' or 'Do not use other eye drops within so many minutes of this medication'* — were not addressed back in 2009 and have been completely left behind.

Currently, these health-improving warnings are entirely unstandardized. Many pharmacies routinely print them in microscopic 2-4 font-sized print, compressed and **unbolded texts**, making them hard to read and tape is not always used to cover the label, so the printing is quickly rubbed off, again, making it impossible to see. For the millions of aging Californians living with low vision, cataracts, or glaucoma, these warnings become practically invisible. This also makes it difficult for other individuals helping the patient like family members, friends or health care providers be aware of the

proper usage of a medication if they are dispensing the medications to a patient. Unfortunately, many of the patients do not keep the Med Guides or Consumer Medication Information provided by the pharmacist at home which can make the situation difficult as well – also supporting the need for auxiliary labeling improving today.

The current system relies entirely on pharmacy-level formatting choices for auxiliary labeling, and these improvements have not voluntarily occurred, and 17 years have passed. Just as the successful labeling changes took place in 2009 to protect the public, I respectfully request that the Board initiate the same process today to begin the process to provide similar legibility standards to auxiliary labeling.

Specifically, I believe a starting point would be for the Board to require that all auxiliary labeling warnings:

1. be provided with a **minimum 6-point, sans-serif font size**.
2. not use compressed lettering for this small font size.
3. utilize **bolded print** to ensure the high contrast necessary for low-vision readers.
4. Benefit from the Board not allowing unnecessary information ~~not~~ on a prescription label that clutters the intended content of the prescription label that results in the proper utilization of the medication. This would be items such as patient & physician addresses and phone numbers, DEA numbers, advertising and non-functioning numbers for other uses other than medication directions, unnecessary dates (allowing a bar code for each prescription). is acceptable.

Thank you for your time & continued commitment to patient safety.

Stephen J. Rosati, R. Ph.

# PETITION FOR PREVENTABLE MEDICATION ERRORS:

Standardizing Legibility for Prescription Auxiliary Labels

**Date:** June 23, 2026
**To:** The California State Board of Pharmacy, Public Comment
**Presented By:** Stephen J. Rosati, R. Ph.
**Contact:** sjrosati@aol.com / 831-245-5344

**1. Summary**

In 2009 revisions in California Code of Regulations Title 16, Section 1707.5 provided for a patient-centered font size (minimum 12-point) for primary prescription text, **however auxiliary labeling remains unregulated.** Today, critical safety warnings on auxiliary labeling — such as *"Take with or without Food," "May Cause Drowsiness," "Do not use other eye drops for a specific period of time" or "Do Not Drive"* — are routinely printed in microscopic, compressed, and unbolded fonts. This regulatory gap poses an immediate, severe safety risk to elderly patients and individuals living with low vision due to age, cataracts, retinal disorders, glaucoma or other disorders.

**2. The Problem: Difficult - Impossible to Read Medication Warnings on Prescription Labels**

- **The Reality of Low Vision:** Over 3.8 million Californians face vision impairment. For these individuals, standard 6-to-8-point auxiliary text blurs completely.
- **Failure to Self-Administer:** When vital warnings are unreadable, patients cannot accurately self-administer their medications, rendering the warnings useless.
- **Current Pharmacy Inconsistency:** Formatting choices are currently left up to individual pharmacy software, leading to widespread inconsistency and zero accountability for legibility and font sizes.

**3. Potential Legibility Failures**

- **Adverse Medical Events:** Severe gastrointestinal damage from missing an unreadable *"Take with Food"*.
- **Dangerous Drug/Food Interactions:** Internal bleeding or toxicity from failing to see a tiny *"Avoid Aspirin"* or *"Avoid Grapefruit"* auxiliary label.
- **Accidents and Falls:** Severe injury or motor vehicle accidents caused by an unreadable, unbolded sedation warning or not to take with alcohol.
- **Failure of Active Ingredients:** With many ophthalmics, not to use other drops for 5, 10 or longer minutes.

**4. Proposed Regulatory Solution**

To fulfill the Board's core mandate of public protection, I respectfully request the Board initiate the process to amend CCR Title 16, Section 1707.5 to include the following standardized mandates for auxiliary labels/warnings:

- **Minimum Font Size:** A mandatory minimum of **6-point font** for all primary text on auxiliary labels/warnings.
- **High Contrast Formatting:** Require text in **bolded, sans-serif font** to ensure legibility for low-vision readers.
- **Uniform Label Layout:** Require high-contrast or color-coded background blocks to clearly separate critical safety text from standard labels. Remove unnecessary information, not limited to: MD and patient phone numbers and addresses, advertising, non-functioning numbers (bar codes ok), DEA numbers.

Thank you very much for considering this request.

> *"Public protection is greatly improved when life-improving directions and warnings are actually visible and readable by the patients who need them most or by those trying to assist and help these patients."*

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Part of Agenda Item V. Auxiliary Labeling

Place at the end of Attachment #2 and will be EXHIBIT #1

The pictures below are of both front and back portions of labels that were actually printed in 2009 and 2010 to meet the proposed label improvements at that time. I included them today, in 2026, to show what the main portion of the label is in 12-point on both labels. RX 362347 is 12-point because there are only 4 lines of directions and RX 361325 is only 8-point showing what happens when the computer automatically adjusts the font size from 12 to 8 point when the directions provided by the physician are longer than the normal 2 to 4 lines (like corticosteroid tablets) for the directions. These were Test Labels, only for showing font sizes, darkness in print and ease in reading the directions and auxiliary portions of the label, so the Xopenex label is totally incorrect in what is stated on the label and there is no shake well, etc.

Now specifically for the auxiliary label portion of the labels below: for RX 362347 the size of the vial is small, 12.2 drams, with the auxiliary-label portion in 6-point BOLD and for RX 361325 the size of the vial is 20 drams, with the auxiliary-label portion in 8-point BOLD due to different sources of the contents of the auxiliary labels. As you view these labels today, both the main label and auxiliary label portions' print look very good because they are in bold print, were taped and been kept in a file cabinet for ~ 16 years so that needs to be considered.

I hope this provides some insight into the value of having at least 6-point, if not 7-point, as a minimum size and the value of using bold print for auxiliary labels/warnings. I also would like to have the Board consider the inclusion that any print on the label, 7-point and less, be required in bold print.

There could be concerns today about more changes to the label, but remember, the original improvements in the past have worked well and it's too bad the auxiliary labeling was left out at that time. What resulted in many cases were illegible auxiliary labeling due to small font size and darkness in print that has not been voluntarily corrected in ~16 years! All the printing on the labels below still look good for their age and given today's larger label sizes and the changes in dimensions/sizes to vials, there is even more flexibility in making these improvements work to benefit the consumer with additional safety in 100% of the label. This added consistency, through a few more changes, will be much easier to put into place than those in 2010.






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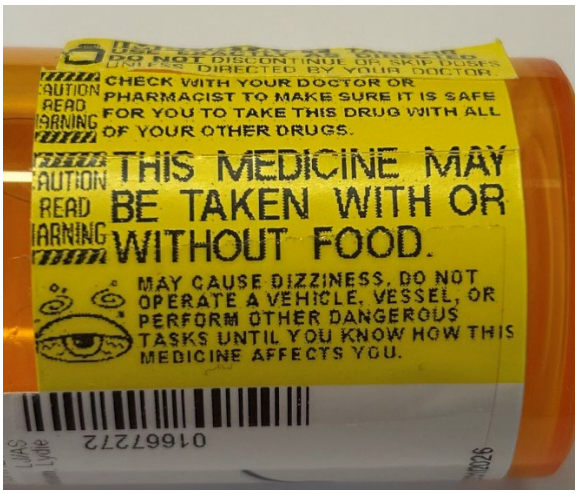
Part of Agenda Item V. Auxiliary Labeling
Place at the end of Attachment #2 and will be EXHIBIT #2

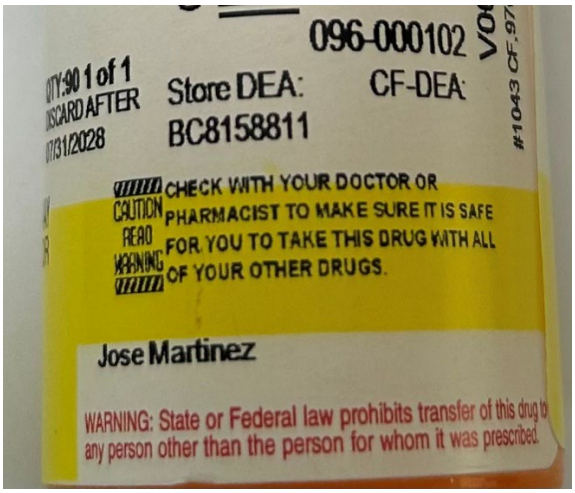
These are pictures of labels for my actual prescriptions filled in 2026 from one of the two pharmacies I get my prescriptions filled. I only zeroed in on the auxiliary labeling portion to show the minimum font size of at least 7 possibly 8, and BOLD print throughout the label, making the labels very clear.

Additionally, the warning about transferring the prescription to another person below is clear, good font size and properly stated which adds the necessary consistency we are looking for today. It's not necessary to require red print but that's not a problem and I think a good idea if one chooses to do so.

I am not sure why the need for Jose Martinez who could be the pharmacist on duty who checked off the prescription, maybe initials would have sufficed after the actual date filled placed to the right of the patient's name on the label; the DEA Number is likely not necessary, plus the "096-000102" which could possibly have been included in the bar code adding to less clutter. Overall, this label is very good with the exceptions I mentioned in the previous sentence.

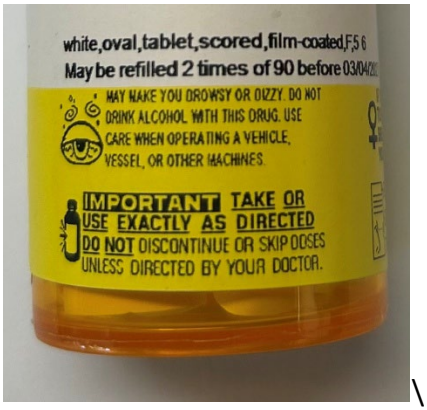
I realize our inspectors have more important issues to deal with, but during an inspection (or another representative from the Board of Pharmacy), look at a few prescriptions ready for pickup to review some of the points to see how much consistency is needed to improve the auxiliary labeling in terms of font sizes, darkness of print, location of all the pertinent dates to avoid confusion and reducing clutter from unnecessary data.









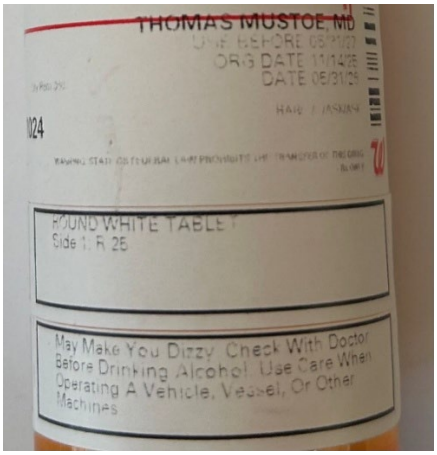

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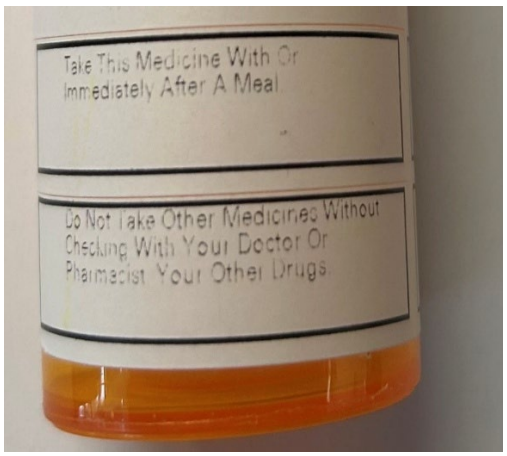
**9/23/2026 CALIFORNIA STATE BOARD OF PHARMACY LICENSING COMMITTEE MEETING**

Part of Agenda Item V. Auxiliary Labeling
Place at the end of Attachment #2 and will be EXHIBIT #3

These are pictures of labels for my actual prescriptions filled in 2026 from the other of my two pharmacies I get my prescriptions filled. I zeroed in on the auxiliary labeling portion to point out the font size of 4 possibly 5, NOT BOLD print, making it difficult to read. Not only does it rub off easily due to the low level of darkness, but the smaller font size leaves less surface area to "adhere" to the label. when you couple all of these points together it is very hard to determine what date refers to what particular item. A LARGER FONT SIZE TO LIKELY 7 RATHER THAN THE 6 I INITIALLY SUGGESTED, BOLD PRINTING ON ANYTHING 7 FONT OR LESS WILL VASTLY IMPROVE THE ABILITY TO SEE AND READ THE LABEL.

As a separate comment, UNRELATED to the auxiliary labeling, please consider the requirement to separate the date the prescription was actually filled from the other dates on the Prescription Label. Instead of locating all three together in one column as depicted on the label below, located on the upper left (it can be confusing to see all the dates together). The date filled (in 12-point font) could be located to the right of the Patient's Name and the original date of the prescription while the remaining refills or expiration date of refills and the expiration of the medication towards the bottom of the label, or on a different side of the label where the date actually filled appears, to help reduce confusion when that particular prescription was filled or refilled. I believe this would make it easier for the patient or caregiver to see what bottle is the current refill and know the last refill date much more easily.




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