

October 2006



Nevada State Board of Pharmacy

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<http://bop.nv.gov>

Published to promote voluntary compliance of pharmacy and drug law.

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Schedule of 2006 Board Meetings

October 25-26 Las Vegas
December 6-7 Reno

Office Use

As a reminder, if a physician needs a drug for use in his office, he may not write a prescription “for office use.” To be transferred from one Drug Enforcement Administration (DEA) registrant to another, a Schedule II drug requires the use of DEA Form 222. Dangerous drugs and controlled substances (CS) in Schedules other than II are sold and transferred by invoice. Both the name and address of the seller and the buyer must appear on the invoice as well as the DEA number of both parties if selling or transferring a CS.

Schedule II Issues

A scenario we have all experienced involves a patient presenting a Schedule II prescription for filling, then deciding, after the fact, that he does not want it filled after all, possibly due to an insurance rejection or prohibitive co-pay, and requests the prescription blank back. You have already numbered, filled, canceled, and signed off on the prescription. Can you give it back, and, if you are the receiving pharmacist of an already canceled prescription, can you fill it? As a matter of policy, the Nevada State Board of Pharmacy has ruled that, yes, you can give it back to the patient; however, you must account for the prescription number in your files with an explanation, as well as show the drug “returned to stock” for inventory purposes. If you are the receiving

pharmacist of a canceled prescription, you must verify with the “canceling” pharmacy that the prescription was indeed not filled.

Also, as a matter of policy, the Board has ruled that multiple prescriptions, including multiple Schedule II prescriptions, may be written on one blank under one signature (as you all see with hospital discharge prescriptions). Each drug on the blank obviously must have its own prescription number. For filing purposes, it is permitted to photocopy the order and use the original in the file of the highest controlled drug, referring to that prescription number on all of the photocopies so that one may locate the original should the need arise.

Both of the above rulings are copacetic with DEA.

Web Site Overhaul

The Board of Pharmacy has engaged in a major, and desperately needed, Web site overhaul! Please visit <http://bop.nv.gov> at your next convenience to peruse our new site.

We are still in the building mode, so not all of the features are completed. You will be able to, among other things, verify a license; get a law book; access the minutes of Board meetings; access this *Newsletter*; download official forms; renew online; look up regulations and statutes; submit a question to staff; and link to Food and Drug Administration, DEA, National Association of Boards of Pharmacy®, United States Pharmacopeia, Pharmacy Technician Certification Board, and other organizations.

Board staff is striving to communicate more with licensees and other interested persons through e-mail. To make this possible, please keep your e-mail address current with us by visiting our Web site and clicking on “Change Licensing Information” and, when added to the site, a button for “Listserv.” We also hope to keep you all current through the use of “e-postcards” announcing such things as continuing education (CE) opportunities.



FDA Launches Consumer Educational Program on the Safe Use of OTCs

The United States Food and Drug Administration's (FDA) Center for Drug Evaluation and Research, in cooperation with the National Council on Patient Information and Education and Maryland's Montgomery County Public Schools, has launched "Medicines in My Home," an interactive educational program aimed at informing middle school students about the safe and effective use of over-the-counter (OTC) medicines. Key concepts students will learn from the program are:

- ◆ the Drug Facts label tells you what a medicine treats, if it is right for you and your problem, and how to use the medicine;
- ◆ read the label and follow the directions carefully and correctly;
- ◆ two medicines with the same active ingredient should not be used at the same time; and
- ◆ measure medicines correctly with measuring tools made for medicines.

The program emphasizes that medicines should be used only with permission from an adult and that if there are questions about medicine use, ask a pharmacist or doctor. Materials are provided to encourage students to share what they learn with their families so that all family members can learn to use OTC medicines more safely. Program information can be found at www.fda.gov/medsinmyhome.

HHS Warns Public of Heroin and Fentanyl Deadly Combo

In efforts to warn the public and health care professional communities regarding a recent rash of drug-related deaths due to an illicit street drug combination consisting of the prescription medication fentanyl and either heroin or cocaine, the Department of Health and Human Services (HHS) released a fact sheet containing specific information with the goal of saving lives.

A letter from H. Westley Clark, director of HHS Center for Substance Abuse Treatment, to health care professionals warned that in "just one week, an estimated 33 individuals in the Detroit, MI area are reported to have died after using this fatal mix of drugs; the same drug combination may have been responsible for more than 100 deaths in the same region last September [2005]." Philadelphia, PA; Chicago, IL; St Louis, MO; and Camden, NJ have also recently experienced similar clusters of drug-related deaths.

Fentanyl, an injectable Schedule II prescription opioid analgesic, is roughly 50 to 80 times more potent than morphine but can also be produced in clandestine laboratories in powder form and then mixed with or substituted for heroin. Fentanyl-related overdoses can result in sudden death through respiratory arrest, cardiac arrest, severe respiratory depression, cardiovascular collapse, or severe anaphylactic reaction. In some cases, heroin or cocaine users are aware they are purchasing this dangerous combination of drugs and in other cases, they are not. Because the potency of street-sold heroin or cocaine is amplified markedly by fentanyl and because the inclusion of fentanyl

may not be disclosed, any use, even a reduced dose, can result in overdose or death. The fact sheet advises that suspected overdoses should be treated rapidly with a naloxone injection, 0.4 to 2 mg intravenously, subcutaneously, or intramuscularly every two to three minutes, which should rapidly reverse symptoms related to a narcotic overdose; if there is no response after 10 minutes, then a different diagnosis should be considered.

For additional information, contact Kenneth Hoffman at the Substance Abuse and Mental Health Services Administration at 240/276-2701 or via e-mail at Kenneth.Hoffman@samhsa.hhs.gov.

Pharmacy Technicians and Medication Error Prevention



This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency that works closely with United States Pharmacopeia (USP) and FDA in analyzing medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, then publishes its recommendations. If you would like to report a problem confidentially to these organizations, go to the ISMP Web site (www.ismp.org) for links with USP, ISMP, and FDA. Or call 1-800/23-ERROR to report directly to the USP-ISMP Medication Errors Reporting Program. ISMP address: 1800 Byberry Rd, Huntingdon Valley, PA 19006. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.

In an October 2005 article in the *American Journal of Health-System Pharmacists*, the results of a random nationwide survey of more than 800 pharmacy technicians' views about their medication errors was published (Desselle SP. Certified pharmacy technicians' views of their medication preparation errors and educational needs. *Am J Health-Syst Pharm*. October 1, 2005; 62:1992-97). Most of the technicians worked in community pharmacies, but more than a quarter (27%) were employed in hospitals.

As one might expect in both settings, interruptions and inadequate staffing were among the most frequent factors perceived to contribute to technician medication preparation errors. Inadequate staffing was perceived as especially problematic in chain pharmacies, while inadequate supervision by pharmacists was cited as a factor more frequently by hospital technicians. It also may come as no surprise that the pharmacists' most frequently cited response to an error that was caught during the checking process was to make the technician aware of the error and require him or her to correct it. However, only about 17% of the technicians reported that the pharmacist had used the error as an opportunity to provide instructions on how to avoid the same or similar errors in the future.

While many of these respondents attributed this responsibility to the organization as a whole, not necessarily the individual pharmacist who detects an error, it appears technicians may not be receiving guidance about system and process changes that can help avert errors. After an

Compliance News

Compliance News to a particular state or jurisdiction should not be assumed (the law of such state or jurisdiction.)



error is corrected, the checking pharmacist should find time that same day (or the next day, if necessary) to review the error with the technician and suggest ways to avoid it, including safer behavioral choices if applicable. Later, during pharmacy staff meetings or other forms of intradepartmental communication, errors, their causes, and ways to prevent them should be shared with all staff in a way that does not embarrass those who were possibly involved in the errors.

One or Both Nostrils?

Submitted by ISMP

Although many nasal sprays are intended for administration in each nostril for a single dose, there are notable exceptions. For example, some medications are meant to be delivered via the nasal passage but **not** sprayed into each nostril. Calcitonin salmon (**Fortical**[®], **Micalcin**[®]) is a prime example. Patients should administer a single spray (200 international units) into one nostril daily, using alternate nostrils each day. Other examples in metered-dose or unit-dose nasal spray containers include butorphanol, desmopressin (**DDAVP**[®]), sumatriptan (**Imitrex**[®]), and zolmitriptan (**Zomig**[®]).

Some pharmacy and/or physician electronic prescribing systems have been preprogrammed to print directions that default to "spray in each nostril" when nasal sprays are selected. For the previously mentioned drugs, this would result in the administration of a double dose of medication. One health care facility recently reported that about 50 patients, who had been prescribed medications intended to be given into one nostril, had prescription container labels that instructed the patients to administer the spray into both nostrils. Some physicians might anticipate patients' confusion and write the prescription for "half" doses in each nostril. Even if instructed to use the spray in one nostril, patients who administer other nasal medications in both nostrils may spray these medications into both nostrils without thinking.

Explicit verbal directions and written instructions that emphasize administration via one nostril only are critical to avoid an overdose.

FDA/ISMP National Campaign to Help Eliminate Ambiguous Medical Abbreviations

FDA and the ISMP have launched a national education campaign that focuses on eliminating the use of potentially harmful abbreviations by health care professionals, medical students, medical writers, and the pharmaceutical industry. The campaign addresses the use of error-prone abbreviations in all forms of medical communication, including written medication orders, computer-generated labels, medication administration records, pharmacy or prescriber computer order entry screens, and commercial medication labeling, packaging, and advertising. For more information visit www.fda.gov/cder/drug/MedErrors.

DEA Provides Retail Training Materials

Drug Enforcement Administration (DEA) recently announced the availability of training materials regarding self-certification training for regulated retail sellers of non-prescription drug products containing

ephedrine, pseudoephedrine, and phenylpropanolamine as required by the Combat Methamphetamine Epidemic Act of 2005 (Title VII of Public Law 109-177).

Two sets of training materials have been developed: one for regulated persons who are mobile retail vendors, and one for regulated persons who are not mobile retail vendors. Both sets of training materials may be found on the Diversion Control Program Web site, www.deadiversion.usdoj.gov, under "Combat Methamphetamine Epidemic Act of 2005."

DEA notes that regulated sellers must use the content of these training materials in the training of their employees who sell scheduled listed chemical products. A regulated seller may utilize additional content in its training program, but DEA's posted material must be included.

DEA is continuing to work to promulgate regulations to implement the Combat Methamphetamine Epidemic Act of 2005.

FDA Announces Release of Guidance on Useful Written Consumer Medication Information

In the July 18, 2006 *Federal Register*, FDA announced the availability of a guidance entitled "Useful Written Consumer Medication Information (CMI)." This guidance is intended to assist individuals or organizations (eg, pharmacies, private vendors, health care associations) in developing useful written consumer medication information to comply with Public Law 104-180. CMI is written information about prescription drugs developed by organizations or individuals, other than a drug's manufacturer, that is intended for distribution to consumers at the time of dispensing. Since neither FDA nor the drug's manufacturer reviews or approves CMI, FDA recommends that the developers of written medication information use the factors discussed in this guidance to help ensure that their CMI is useful to consumers.

This guidance can be accessed at www.fda.gov/cder/guidance/7139fnl.htm.

2007 Survey of Pharmacy Law Available Soon

NABP's 2007 *Survey of Pharmacy Law* CD-ROM will be available in early December 2006. New topics include whether or not licensure for wholesale distributors of non-prescription drugs is required and the recognition of Verified-Accredited Wholesale Distributors[™] accreditation.

The *Survey* consists of four sections: organizational law, licensing law, drug law, and census data. The *Survey* can be obtained for \$20 from NABP by downloading the publication order form from www.nabp.net and mailing in the form and a money order to NABP. The CD-ROM is provided free of charge to all final-year pharmacy students through a grant from AstraZeneca Pharmaceuticals. If you do not have Web access or would like more information on the *Survey*, please contact NABP at 847/391-4406 or via e-mail at custserv@nabp.net.

Faxing Controlled Substance Prescriptions

One of the ongoing inquiries to the Board office by pharmacists and the apparent source of some confusion is the subject of the faxing of a CS prescription to a pharmacy. For reference, please explore NAC 639.711 (“Transmission of prescriptions by facsimile machine”).

Here are the rules:

1. A prescription for a dangerous drug or a [CS] in Schedule III, IV, or V may be faxed to a pharmacy provided the patient consents to the use of the fax and to which pharmacy it is being faxed. The fax must also be signed by the practitioner and be faxed from the practitioner’s office as is evidenced by header information. Confusion for pharmacists arises when a fax is generated by an approved electronic system and sent directly to the pharmacy. Since the prescription is electronically generated and stored in the physician’s office, there is no paper available for the physician to sign, so an “electronic signature” is acceptable. If the pharmacist has any question as to the validity of the prescription, he or she may verify the fax through the physician’s office.
2. A prescription for a [CS] in Schedule II may **not** be transmitted by fax unless:
 - a. It is for a compounded substance for direct administration to a patient parenterally or for intraspinal infusion.
 - b. It is for a patient who is a resident of a long-term care facility.
 - c. It is for a patient enrolled in licensed hospice care and is so indicated on the face of the prescription.

License Renewal Notice

This month ends the license renewal period for all licensees **with the exception of pharmacists**. The re-

newal application deadline is October 31, 2006. **Postage meter dates are not considered US Postal Service postmarks.**

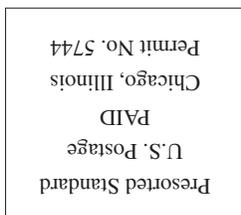
It is important to ensure that all employees who are regulated by the Board, working in the pharmacy, are properly licensed. All managing pharmacists need to check licenses for current expiration dates. Should someone not renew by the October 31 deadline **he or she is not allowed to work until he or she does**. You can go online to verify the license at <http://bop.nv.gov> then click on “Verify a License,” input the license (file) number **only**, and find out if he or she is current.

As a side note, for pharmacists to meet their own renewal requirements there will be a law CE session in Reno on December 2, 2006. Please watch for details or check our Web site.

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