



Nevada State Board of Pharmacy

Published to promote compliance of pharmacy and drug law

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Medical Conditions

NAC 639.707(4) states in part that “The pharmacist or intern pharmacist shall review a patient’s record before dispensing a prescription to determine its therapeutic appropriateness by considering: . . . (2) Diseases which the patient has, including any stages of that disease.” Nevada State Board of Pharmacy inspectors are reporting that this function simply is not being accomplished in many practices, evidenced by the lack of even a section within many computer systems to record such data. The value of such information is obvious, affording the pharmacist a much clearer picture of a patient’s health and the ramifications of certain medications on that health. To illustrate, knowing that your patient is pregnant would be critical when dispensing tetracycline or that your patient is a severe asthmatic when ordered aspirin or a beta blocker.

Board staff encourages all pharmacists to make an effort to comply with this regulation, not only for your patient’s sake, but for your own protection. The Board is sensitive to the fact that you are all extremely busy; however, patient safety must be your primary concern and the more information available to you about your patients, the better the care will be.

Fred T. Mahaffey Award

The Nevada State Board of Pharmacy has been selected as this year’s recipient of the Fred T. Mahaffey Award by the Executive Committee of the National Association of Boards of Pharmacy® (NABP®). The award was presented at the NABP 106th Annual Meeting in Anaheim, CA, in May.

Named in honor of the late NABP executive director emeritus, the Fred T. Mahaffey Award recognizes a board of pharmacy that has made substantial contributions to the regulation of the pharmacy profession during the past year. The nominated board’s efforts must have contributed to the protection of the public health and welfare through the enforcement of state and federal laws and regulations, and to the advancement of NABP goals and objectives.

The Nevada Board is being honored for its “inspecting for safety” initiative, this being the Nevada Board’s second Mahaffey Award in the past five years!

Readily Available

There seems to be some confusion in regard to what information may be deemed “readily available,” by indicating “R.A.” or some similar indication with a pharmacist’s initials, on a controlled substance prescription. CFR §1306.05 requires the address of the patient as well as the address and Drug Enforcement Administration (DEA) registration number of the practitioner to be on the prescription. NAC 453.440(3) allows the pharmacist to use “R.A.” for the address if readily available, however does **not** allow the pharmacist to use the same for the DEA registration number. Bottom line: if the DEA number for the practitioner is missing, the pharmacist must add it, and must place his initials near that entry.

Immunization Update

Effective January 28, 2010, all Advisory Committee on Immunization Practices-recommended vaccinations administered to **children and adults must be recorded** in Nevada WebIZ. To download the new regulations, forms, and instructions, please visit http://health.nv.gov/Immunization_WebIZ_Policies_Forms.htm.

Questions? Call 775/684-5954 or 877/NV-WebIZ.

Compression Stockings

Reminder: Compression stockings rated 18 mm or higher may only be sold pursuant to a prescription as of August 26,

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FDA Updates 'Medicines in My Home' Patient Education Resources

Food and Drug Administration (FDA) has updated the Medicines in My Home (MIMH) section of the agency's Web site with new resources and materials for patients. MIMH resources teach patients from adolescence through adulthood how to choose over-the-counter (OTC) medicines and how to use them safely. An interactive video teaches users how to understand the drug facts label and make sound medicine decisions. Downloadable documents provide information on caffeine use, choosing appropriate OTC medications, and other related topics. The MIMH Web page can be accessed at www.fda.gov/Drugs/Resources/ForYou/Consumers/BuyingUsingMedicineSafely/UnderstandingOver-the-CounterMedicines/ucm092139.htm.

DEA Releases e-Prescription for Controlled Substances Interim Final Rule

The Drug Enforcement Administration (DEA) Interim Final Rule on electronic prescriptions for controlled substances was published in the *Federal Register* on March 31, 2010, and was scheduled to go into effect June 1, 2010, subject to Congressional review. The regulations would allow prescribers the option to write prescriptions for controlled substances electronically, and allow pharmacies to receive, dispense, and archive these electronic prescriptions. The regulations are an addition to existing rules, and include stipulations to ensure that a closed system of controls on controlled substances dispensing is maintained. The regulations have the potential to reduce prescription forgery and reduce the number of prescription errors, and should also reduce paperwork and help integrate prescription records into other medical records.

Confirmation Bias



This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency that analyzes 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, and publishes its recommendations. To read about the risk reduction strategies that you can put into practice today, subscribe to ISMP Medication Safety Alert!® Community/Ambulatory Care Edition by visiting www.ismp.org. ISMP is a federally certified patient safety organization, providing legal protection and confidentiality for submitted patient safety data and error reports. ISMP is also a FDA MedWatch partner. Call 1-800-FAIL-SAF(E) to report medication errors to the ISMP Medication Errors Reporting Program or report online at www.ismp.org. ISMP address: 200 Lakeside Dr, Suite 200, Horsham, PA 19044. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.

Although pharmaceutical companies and regulatory agencies have been working on design changes to improve the situation, ISMP still associates many medication errors with confusion over "look-alike" or "sound-alike" product names. Since patients receive the wrong drug, these sometimes result in serious harm. A common cause of name mix-ups is what human factors experts call "confirmation bias." Confirmation bias refers to a type of selective thinking whereby individuals select what is familiar to them or what they expect to see, rather than what is actually there.

Many errors often occur when pharmacists or technicians, due to familiarity with certain products, see the name of the product they think it is rather than what it actually is. For instance, if a pharmacist reads a poorly written drug name, he or she is most likely to see a name that is most familiar to him or her, overlooking any disconfirming evidence. Another example of this is if a pharmacy technician chooses a medication container based on a mental picture of the item, whether it is a characteristic of the drug label, the shape, size, or color of the container, or the location of the item on a shelf.

Although various compilations of look-alike name pairs are available for posting (see www.ismp.org/Tools/confuseddrugnames.pdf for ISMP's List of Confused Drug names, which has recently been updated), these lists have only limited usefulness since it is impossible for practitioners to memorize them in order to know when to check on questionable prescriptions. Also, when confirmation bias occurs, there is never a reason for the practitioner to question the order to begin with.

In many cases, hospital or pharmacy computer systems can be used to reduce the risk of confirmation bias and resulting name mix-ups. Many systems have a "formulary note" field that can be easily adapted to display important information prominently on the computer screen. Similar to a road sign warning about a dangerous intersection ahead, this feature can be used to alert the person inputting the medication when a look-alike or sound-alike danger is present. For example, when *Norvase*® is entered into the computer, a formulary note screen appears, alerting the pharmacist that *Norvasc* often looks like *Navane*® when handwritten. The pharmacist will then take the necessary steps to confirm the prescription if necessary.

In addition, physically separating drugs with look-alike labels and packaging helps to reduce this confirmation bias as does implementing bar-coding technology for the verification process of drug selection. Employing a simple system that compares computer-generated National Drug Codes (NDC) on prescription labels and NDC codes on manufacturers' containers to verify that the appropriate drug has been selected and dispensed also helps reduce confirmation bias.

It is human nature for people to associate items by certain characteristics. It is very important for the health care community and regulators to recognize the role that confirmation bias may play in medication errors and to work together to address associated problems.

FDA-TRACK Provides Public Access to Agency's Performance Data

The new FDA-TRACK will provide access to updated information about FDA programs, projects, and core responsibilities. The system is part of the FDA transparency initiative and its objectives are represented in the TRACK name which stands for transparency, results, accountability, credibility, and knowledge-sharing. This agency-wide system will track performance measurement data reported from over 100 FDA program offices. Common measures, key center director measures, program measures, and key projects are the measurement areas currently in use, and more information about these areas is available in the FDA-TRACK announcement available at www.fda.gov/AboutFDA/WhatWeDo/track/default.htm. FDA-TRACK will continue to be updated and the latest information can be found on the following Web pages: Cross-Agency FDA-TRACK Program Areas available at www.fda.gov/AboutFDA/WhatWeDo/track/ucm206441.htm, Center FDA-TRACK Program Areas available at www.fda.gov/AboutFDA/WhatWeDo/track/ucm206441.htm.



AboutFDA/WhatWeDo/track/ucm195008.htm, and Dashboards available at *www.fda.gov/AboutFDA/WhatWeDo/track/ucm195011.htm*. Public feedback on FDA-Track and its measures can be submitted by e-mail to FDATRACK@fda.hhs.gov.

Survey Suggests Majority of Patients Seek Pharmacist Advice About OTC Medications

When selecting OTC medications, 82% of pharmacy customers base their decision on a pharmacist's recommendation, according to a survey of over 1,000 pharmacists conducted by the American Pharmacists Association (APhA). Survey results also indicate which products, among 76 categories presented to pharmacists, are most often recommended. The survey results are published in the Pharmacy Today Over-the-Counter Supplement available at *www.imirus.com/tmp/2536/2501/1001/pm2536.pdf*. An APhA news release, available at *www.pharmacist.com/AM/Template.cfm?Section=News_Releases2&Template=/CM/ContentDisplay.cfm&ContentID=23117*, indicates that 90% of patients seek help identifying the most appropriate product and 80% seek counsel regarding using an OTC product with their prescription medications.

California PMP Data Shows Frequency of Doctor Shopping

Early data collected from California's prescription monitoring program (PMP), the Controlled Substances Utilization Review and Evaluation System (CURES), correlates the frequency of patient "doctor shopping," or obtaining multiple prescriptions from various providers, with the number of prescriptions patients receive for additional controlled substances, as reported in *Medical News Today*. The research analysis, presented at the American Academy of Pain Medicine 26th Annual Meeting, showed that patients prescribed a single additional class of a controlled substance, such as benzodiazepines, had a two-fold likelihood of doctor shopping for multiple opioid prescriptions. A 13-fold increase in doctor shopping was seen when more than one additional drug class was involved. Researchers at the University of California, Davis, conducted the analysis using de-identified CURES data, and also found that patients involved in doctor shopping were involved in more than one episode about 50% of the time.

Highest Dose of Zocor Increases Risk of Muscle Injury, FDA Warns

FDA has informed health care practitioners that there is an increased risk of muscle injury in patients taking the highest approved dose of the cholesterol-lowering medication, Zocor[®] (simvastatin) 80 mg. This information is based on review of data from a large clinical trial and other sources, and FDA is currently reviewing additional data to better understand the relationship between high-dose simvastatin use and muscle injury. More information is included in an FDA Drug Safety Communication at *www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm204882.htm*.

New OxyContin Formulation to Help Prevent Abuse of the Drug

FDA has approved a new formulation of the controlled-release drug OxyContin[®] which is designed to decrease the likelihood that this medication will be misused or abused, and result in overdose. FDA explains that the new formulation adds in new tamper-resistant features aimed at

preserving the controlled release of the active ingredient, oxycodone. The old formulation allowed tampering with the tablet, via cutting, chewing, breaking, or dissolving, which resulted in dangerously high levels of oxycodone being released at once. In accordance with FDA requirements, Purdue Pharma L.P. will conduct a post-marketing study to determine the impact of the new formulation, and the manufacturers will follow a Risk Evaluation and Mitigation Strategy (REMS) for this product. The REMS will include the issuance of a Medication Guide to all patients who use the product. More information is provided on the FDA OxyContin Question and Answer Web page at *www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm207196.htm*.

Use of e-Prescribing Grows Dramatically

The number of electronic prescriptions increased 181% from 2008 to 2009, according to the 2009 National Progress Report on E-Prescribing, published by Surescripts, operator of the largest e-prescription network that connects prescribers' e-prescribing software to pharmacies. Over 190 million e-prescriptions were routed in 2009, compared with 68 million in 2008, and 29 million in 2007. Correlating with those increases, 156,000 prescribers were using e-prescriptions by the end of 2009 compared with 74,000 at the end of 2008, a 109% increase. The report also indicates that 85% of community pharmacies in the United States are connected and able to receive e-prescriptions from prescribers.

Study Shows e-Prescribing Reduces Prescriber Errors

Prescribers using e-prescribing were seven times less likely to make errors than those writing their prescriptions by hand, according to a new study published in the *Journal of General Internal Medicine*. The study, conducted by researchers at Weill Cornell Medical College, focused on 12 community practices and compared the prescriptions of 15 providers using e-prescribing and 15 providers writing prescriptions by hand. The researchers found that two in five handwritten prescriptions contained errors such as incomplete directions, prescribing a medication but omitting the quantity, and prescribing incorrect dosages. Further, comparing handwritten prescriptions and e-prescriptions one year from the start of the study, researchers found that errors dropped from 42.5% to 6.6% for the providers using e-prescriptions. Errors associated with the handwritten prescriptions in the study increased from 37.3% to 38.4% a Weill Cornell Medical College press release providing more information about the study is available at http://weill.cornell.edu/news/releases/wcmc/wcmc_2010/02_26_10.shtml.

Counterfeit Drug Investigation Leads to Two Arrests

Two individuals have been arrested and face charges related to illegally importing counterfeit weight-loss medication. FDA issued a series of alerts, from 2008 to 2010, about tainted weight-loss pills and counterfeit drugs, and an undercover investigation identified one of the defendants as the alleged trafficker of these tainted and counterfeit drugs. This investigation was a joint effort by FDA Office of Criminal Investigations, US Immigration and Customs Enforcement, and US Postal Inspection Service. More information about the investigation and arrests is available in a US Attorney's Office Press Release at *www.fda.gov/ICECI/CriminalInvestigations/ucm206314.htm*.

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2008. Board inspectors still occasionally find stockings with these ratings in the over-the-counter section of some pharmacies. Check your stock!

Tech's Corner

By Kim Pinson

Since the 1950s, pharmacists have had pharmacy technicians by their side to assist in the practice of pharmacy, each complementing the other like peanut butter and jelly. However, simple concepts can become confusing when pharmacy law is applied to the pharmacist's licensure and the technician's registration. The legal counsel for the Nevada State Board of Pharmacy likens the licensure and registration to that of a car and driver.

Licensure in either scenario, that of a pharmacist or that of a driver, cannot be obtained without intense study and practice with competency shown through testing. Earning a license shows responsibility for the knowledge required to perform and carry out specific tasks.

In comparison, a pharmacy technician's registration is similar to that of the car. Registration is necessary to gain access to perform a certain function. A registration does not require a test of any knowledge and is granted upon providing required information and paying a fee.

Keeping the car and driver concept in mind, when it comes to legal and disciplinary action, the repercussions are diverse. In legal matters involving pharmacy technicians (or cars), fines can be incurred as well as losing the registration. That person will not be able to be employed as a pharmacy technician any longer but has freedom to pursue another job without consequence. However, if you were to lose your driver's license, you lose the ability to perform that specific task, legally. A pharmacist, who has lost his or her license, loses his or her livelihood. The accomplishment they worked years for, is gone. The pharmacist places his or her license on the line each day of practice. Working beside them, the technicians must be diligent in their work helping to protect that license. The simplified scenario is not meant to belittle the difference, but

to increase the awareness of how heightened attentiveness can protect all involved.

The pharmacist has a unique opportunity to promote the development of his or her technicians and instill the work ethic and moral values he or she expects in practice. Without a current standard of competency or training for the technician, the pharmacist can also be a key player in helping technicians reach their full professional potential. Our obligation as technicians is not only to our pharmacists and to ourselves, but also in helping protect the patients to whom we serve. We absolutely have a reciprocal role in protecting one another's actions with respect to the work we perform in the pharmacy. If one fails, they both do. Technicians must be a second set of eyes and ears for their pharmacist. As a pharmacist's responsibilities increase, technicians are being utilized in higher capacities. The information we process must not be taken lightly. A technician must always refer to the pharmacist for medication information, questions, and health matters. We must take care in the tasks we perform and always remember that lack of attention to detail can be a matter of life and death.

The Nevada State Board of Pharmacy reminds pharmacists that "technicians in training" need to register at each pharmacy that they are accruing their 1,500 hours at to qualify for full registration. Failure to comply may end up in a forfeiture of those hours worked. A registered pharmacy technician must provide the Board with the name of each pharmacy in which they work.

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