TENNESSEE BOARD OF PHARMACY
665 Mainstream Drive, Iris Room
Nashville, TN
March 14, 2017

BOARD MEMBERS PRESENT
Kevin Eidson, D.Ph., President
Michael Dickenson, D.Ph. Vice President
Rissa Pryse, D.Ph.
Debra Wilson, D.Ph.
Will Bunch, D.Ph.
Katy Wright, D.Ph.

STAFF PRESENT
Reginald Dilliard, Executive Director
Matthew Gibbs, Assistant General Counsel
Terry Grinder, Pharmacy Investigator
Rebecca Moak, Pharmacy Investigator
Andrea Miller, Pharmacy Investigator
Tommy Chrisp, Pharmacy Investigator
Robert Shutt, Pharmacy Investigator
Larry Hill, Pharmacy Investigator
Scott Denaburg, Pharmacy Investigator
Sheila Bush, Administrative Director

BOARD MEMBER ABSENT
Lisa Tittle, Consumer Member

STAFF ABSENT
Richard Hadden, Pharmacy Investigator

The Tennessee Board of Pharmacy convened on Tuesday, March 14, 2017, in the Iris Room, 665 Mainstream Drive, Nashville, TN. A quorum of the members being present, the meeting was called to order at 9:00 a.m. Dr. Eidson welcomed students from Belmont University, Lipscomb University, South College and East Tennessee State University.

Minutes

The minutes from the January 24, 2017 board meeting. Dr. Dickenson made the motion to accept the minutes as presented. Dr. Pryse seconded the motion. The motion carried.

Order of Compliance
Medisca

Lisa Revere, Attorney for Medisca, appeared before the board to ask that the probationary status be lifted from their license. Medisca license was placed on indefinite probation at the May 15, 2013 for violated T.C.A. § 53-10-305 (1), (2), (4) & (5). After discussion, Dr. Wilson made the motion to issue an Order of Compliance, lifting the probationary status, to Medisca. Dr. Pryse seconded the motion. The motion carried.

General Discussion

Mr. Gibbs introduced Melissa Painter Procurement Officer to the board to discuss the grant proposal and the process. Ms. Painter stated that roughly 30 to 40 days from posting for the committee to review the grant. Dr. Bunch is on the committee but this is not public record until the contract has been signed.

OGC Report

Mr. Gibbs informed the board that there are 66 open cases for discipline at the Office of General Counsel and 26 of those cases are eligible for contested cases.

Mr. Gibbs informed the board that on January 30, 2017, the General Assembly's Joint Government Operations Committee recommended the rule packet to be included in the rules omnibus bill. The rules took effect on February 22, 2017.

Mr. Gibbs explained to the board that proposed rule language for 3PL providers will be distributed to the board prior to the end of the day. Please plan to discuss the proposed language during the May 2017 meeting.

Legislative Update

Mr. Gibbs presented the following bills for the board to review:

SB1423/HB1327 – Bureau of TennCare to compile a list of 15 prescription drugs which the state spends significant healthcare dollars toward and which have increased in price by 50% over the last five years (or 15% in the last year) ("the list") and provide the list to the commissioner of health ("Commissioner"). The Commissioner is then required to contact the manufacturers, ascertain reasons for the increase, and report to the General Assembly. The Attorney General is given enforcement powers.

SB1181/HB1054 – Caption bill. Allows owners / possessors of misbranded / adulterated drugs 15 days to file written notice requesting a hearing. (T.C.A. § 53-10-106).

SB1119/HB0830 – Medical Cannabis Access Act

SB0518 / HB1222 – Distribution of dialysate from manufacturers to end-users.

SB0385 / HB0694 – Adds FDA approved canabidiol to the list of exceptions found in the criminal definition of marijuana (T.C.A. § 39-17-402(16))

SB0268 / HB1148 – Caption bill. Allows out-of-state pharmacies 21 days to report out-of-state discipline to the TN BOP. Current law requires 14 days to report. (T.C.A. § 63-10-216)

SB0974 / HB0936 – Removes requirement of an in-state institution of higher learning obtain DEA registration prior to conducting research on low-THC cannabis oil.

SB1258/HB0630 – Changes the definition of device to those things "used in to administer a prescription drug."

SB1320 / HB0519 – Requires a report to be submitted to committees of the General Assembly regarding the quantity and kinds of drugs disposed of in the pharmacy drug disposal program and the number and geographic distribution of participating pharmacies.

SB0429 / HB0137 – Deletes the Nina Norman Prescription Drug Donation Act of 1996. Adds a drug repository program.

Agreed Order
Carli Ferrera, RT

Ms. Ferrera's pharmacy technician registration was revoked at the September 20-21, 2016 board meeting for violated T.C.A. § 63-10-305. Ms. Ferrera submitted a Petition for Reconsideration with the Administrative Procedure Division in October of 2016. Mr. Randy Fishman represented Ms. Ferrera Ms. Ferrera has agreed that she violated T.C. A. 63-10-305 (b). Her registration as a pharmacy technician will be suspended for a period of six (6) months, beginning on September 22, 2016 and concluding on March 22, 2017. After the suspension, Ms. Ferrera's registration will be placed on probation for a two (2) years and she will be responsible for case cost to be paid within five (5) years. Dr. Bunch made the motion to accept the agreed order as presented. Dr. Pryse seconded the motion. The motion carried. After further discussion, Dr. Bunch amended his motion to place Dr. Ferrera's pharmacy technician registration on probation for minimum of two (2) years and will remain on probation until she has paid all cost assessed in this case or five (5) years. Dr. Pryse seconded the amended motion. The motion carried. Dr. Dickenson voted no.

Director's Report

Dr. Dilliard asked the board that he has been receiving calls concerning pharmacies that hold prescription placed on file and then transfer. The Federal Drug Act (FDA) rule states that the prescription for controlled substances cannot be transferred because it will be considered as a refill The opinion that has been express is that if it has not been filled it cannot be transferred.

Dr. Dilliard asked the board to replace Dr. Wilson as a member of the Controlled Substance Monitoring Database Committee. Dr. Dickenson volunteer to replace Dr. Wilson. Dr. Wright made the motion to appoint Dr. Dickenson to the CSMD committee. Dr. Pryse seconded the motion. The motion carried.

Dr. Dilliard asked the board for guidance on the rules pertaining to the registering automated dispensing machines (ADM). Dr. Dilliard stated that the rule is using the words "systems" and "machines" interchangeable. After discussion, Dr. Wilson made the motion to that hospitals will be classified as a "system" with one registered ADM and for long term care facilities each facility will need to be licensed as a system with each ADM listed. Dr. Dickenson seconded the motion. The motion carried. Dr. Wilson made the motion that a system is considered to be all machines under a pharmacy license and we would need to know the locations of the machines. Dr. Wright seconded the motion. The motion carried.

Application Review
Jennifer Tucker, D.Ph.

Dr. Tucker is applying for license as a pharmacist in Tennessee by reciprocity. She answered yes to the questions that asks "Have you ever voluntarily surrendered your pharmacist license or any pharmacist registration issued by a federal or state controlled substance authority", "Has your pharmacist license in any jurisdiction ever been revoked, suspended, restricted, terminated, or otherwise been subject to disciplinary action (public or private) by any board of pharmacy or other state authority?", "Have you ever been charged or convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than minor traffic offenses) whether or not

sentence was imposed, suspended, expunged, or whether you were pardoned from any such offense?" and "Have you ever had any application for initial licensure, renewal licensure, or licensure by transfer denied by any licensing authority whether in pharmacy or other profession?". Dr. Tucker stated that she voluntarily surrendered her Mississippi license on September 15, 2011 due to addiction. Dr. Tucker reinstated her Mississippi license with a 10 year probation on January 23, 2013. Her Illinois pharmacist license was revoke on February 27, 2013 due to the voluntary surrender of her Mississippi pharmacist license. After discussion, Dr. Dickenson made the motion to approve Dr. Tucker's application for licensure by reciprocity once all the requirement are met and that the board mirror the Mississippi Consent Order. Dr. Bunch seconded the motion. The motion carried.

Complaint Summary

Case 1.

Complaint alleges unprofessional conduct by respondent pharmacy due to charging differing copays on a medication from 2013 until November, 2106, and refusing to refund the amount of overcharges that the complainant calculated.

Respondent pharmacy had 2 discount cards on file for the complainant and admitted that both cards were not tried on every prescription to see which offered the most discount. Respondent staff provided BOP Investigator with patient's profile along with calculations showing each transaction and the difference in pricing using each discount card. The calculated amount was offered as a refund to the patient.

Recommend: Dismiss

Dr. Bunch made the motion to accept counsel's recommendation. Dr. Dickenson seconded the motion. The motion carried.

Case 2.

Respondent technician admitted in writing to removing 13 Hydrocodone APAP 7.5/325 from the pharmacy.

Recommend: Revoke tech registration

Dr. Wilson made the motion to authorize a formal hearing for revocation. Dr. Dickenson seconded the motion. The motion carried.

Case 3.

During a periodic inspection, BOP Investigator discovered the PIC had taken a 90 day maternity leave, but a replacement PIC was not officially named. PIC was absent for more than 30 days, violating Rule 1140-03-.14 (2) (b). A complete inventory of controlled substances was not conducted before the PIC's departure or upon the PIC's return as required by Rule 1140-03-.14 (4) and (6). PIC admitted there was no emergency that would have prevented the inventory from being conducted.

Recommend: LOI to respondent pharmacy for failure to notify BOP as required in 1140-03-.14 (2) (b).

Dr. Dickenson made the motion to issue Letter of Instruction to the pharmacy for failure to notify the board as required by board rule 1140-03-.14 (20 (b). Dr. Pryse seconded the motion. The motion carried.

Case 4.

This is the PIC for Case 3 above.

Recommend: LOI to respondent pharmacist for failure to conduct controlled substance inventories as required in 1140-03-.14 (4) and (6).

Dr. Dickenson made the motion to issue a Letter of Instruction to respondent pharmacist for failure to conduct controlled substance inventories as required in 1140-03-.14 (4) and (6). Dr. Wright seconded the motion. The motion carried.

Case 5.

Complainant alleged respondent pharmacy used complainant's name and DEA number to process a prescription that the complainant did not authorize. The wrong information was also transmitted to CSMD.

Filling pharmacist admitted to BOP Investigator that the allegation was true and that the complainant's name was on a sticker attached to the prescription. The name was used as the prescriber because the true prescriber's signature was illegible and the hospital was called but nobody was able to verify the true prescriber. There was a DEA number under the true prescriber's signature but it did not cross reference in the pharmacy's system.

Recommend: Dismiss against the pharmacy, but LOI to filling pharmacist

Dr. Dickenson made the motion to dismiss the complaint against the pharmacy but to issue a Letter of Instruction to the filing pharmacist. Dr. Wilson seconded the motion. Dr. Bunch voted no.

Case 6.

This is the filling pharmacist for Case 5 above.

Recommend: LOI for verifying correct prescriber.

Dr. Dickenson made the motion to issue a Letter of Instruction to the filing pharmacist on verifying the correct prescriber. Dr. Wilson seconded the motion. Dr. Bunch voted no.

Case 7.

Loss prevention reported to BOP office that respondent technician admitted to diversion of controlled substances from prepared vials. Loss prevention provided a copy of a written statement admitting to theft of controlled substances.

Recommend: Revoke tech registration

Dr. Dickenson made the motion to authorize a formal hearing for revocation. Dr. Wright seconded the motion. The motion carried.

Case 8.

Complainant alleged 2 misfills occurred. First, a refill for Losartan was incorrectly filled with Donepezil. Patient took the incorrect medication for 2 days before a nurse at work checked his blood pressure at 157/118. When the error was discovered, complainant reports having to spend copious amounts of time trying to speak to someone at the dispensing pharmacy, before finally calling corporate offices and speaking to a supervisor. The supervisor arranged for the patient to return the incorrect medication to another store location and to pick up 4 tablets of the correct medication to last until the patient could return to the pharmacy where the error occurred, which was 52 miles away.

The second misfill occurred when the patient returned to the original dispensing pharmacy to get the correct medication. Upon arriving at home, the patient discovered the replacement bottle was 30 tablets short and had to return to the pharmacy to get the remainder.

BOP Investigator reviewed the filling process at the pharmacy where the errors occurred. Investigator discovered that the same pharmacist committed both errors. Investigator also discovered that the pharmacy uses an accuracy scan for verification. The accuracy scan was by-passed by a technician. When the pharmacist performs product verification, the system indicates that the scan was by-passed but does not state why. Neither pharmacist on duty knew how to retrieve the information showing why the scan was by-passed. The second error/shortage occurred because a stock bottle was dispensed but nobody checked to see that it had been opened and some tablets had been used from that bottle.

Recommend: LOW for accuracy and to submit an acceptable corrective action plan to ensure policies and procedures are followed.

Dr. Bunch made the motion to issue a Letter of Warning for accuracy and that the pharmacy submit an acceptable corrective action plan to ensure policies and procedures are followed. Dr. Wright seconded the motion. The motion carried.

Case 9.

This is the dispensing pharmacist and PIC for Case 8 above.

Recommend: LOW for accuracy

Dr. Bunch made the motion to issue a Letter of Warning for accuracy to the dispensing pharmacist. Dr. Wright seconded the motion. The motion carried.

Case 10.

Loss prevention and management reported shortages and suspicious activity to BOP Investigator. Suspicious activities included: bottles being pulled from shelves, placed between trashcan liners, then later, trash bags being taken out of the pharmacy; respondent being seen on video placing a bottle in a white plastic bag, grabbing a purse and exiting the building without following policy of showing the store manager the contents of the bag; drugs in question being ordered on nights the respondent was working late, then being diverted the next day when the shipment arrived. Respondent denied all allegations to Loss prevention. BOP Investigator contacted respondent who claimed to be working in another state and will be relocating. Certified mail is now being refused and respondent has not provided a letter of response as promised to BOP Investigator.

DEA 106 indicates the following shortages:

2,101 ml Promethazine with Codeine syrup

9,783 Alprazolam 2mg tablets

Recommend: Revoke tech registration

Dr. Pryse made the motion to authorize a formal hearing for revocation. Dr. Wilson seconded the motion. The motion carried.

Case 11.

Pharmacy management reported to BOP Investigator that respondent technician was suspected of diversion. After noticing losses, complainant began an investigation and review of a manual perpetual inventory log that appears to have had information spliced and placed over the original entries. A video was provided to BOP Investigator that shows respondent pulling paper labels from a shred bin, cutting a piece of the paper, and sticking it in the log book. PIC ran a dispensing report and found that 3 of the recent transactions' dispensing dates had been altered. Additional review found the following controlled substances missing:

6,508 Hydrocodone APAP 10/325

13,600 Hydrocodone APAP 10/325

7,648 Oxycodone APAP 10/325

1,950 Oxycodone 15mg

1,050 Oxycodone 30 mg

345 Oxycodone 20mg

4,858 Alprazolam 1mg

2,799 Alprazolam 2mg

90 Oxycodone 20mg

PIC found more altered perpetual log medications from last year. It was also noted that there were no splicing on days that the respondent was not on duty, but resumed when respondent returned to work

Respondent denied all allegations to management. Respondent denied all allegations to BOP Investigator and provided a sworn, written statement of denial. Respondent told BOP Investigator that sometimes a label needs to be cut with scissors so that a long set of directions are placed "after the packaging." Respondent stated that a pharmacist would always make the change. BOP Investigator saw no extended directions in the perpetual log but did note that each line item was initialed by respondent. Police investigation is ongoing, but according to a police detective, respondent will be charged with a felony.

Recommend: Revoke tech registration

Dr. Dickenson made the motion to authorize a formal hearing for revocation. Dr. Pryse seconded the motion. The motion carried.

Case 12.

Loss prevention notified BOP office of missing controlled substances. Respondent technician admitted in a written statement to stealing about 200 each of Norco 10/325 and Alprazolam (no strength given.) Audit revealed 3,647 Alprazolam of various strengths were missing. Respondent denied being responsible for the additional shortages.

Recommend: Revoke tech registration and continue investigation

Dr. Dickenson made the motion to authorize a formal hearing for revocation and to continue the investigation. Dr. Wright seconded the motion. The motion carried.

Case 13.

During a periodic inspection, BOP Investigator discovered respondent pharmacy did not have hot water and was without hot water for at least 2 days. There had been no repair requested until Investigator instructed PIC to have it fixed immediately.

Recommend: Civil penalty of $50 per day for 2 days = $100

Dr. Dickenson made the motion to issue a Letter of Instruction to the pharmacy for not having hot water for two days. Dr. Pryse seconded the motion. The motion carried.

Case 14.

During a periodic inspection, BOP Investigator discovered respondent pharmacy did not have hot water. Investigator was not able to confirm how long the hot water had been inoperable, but there had been no repair requested until Investigator instructed the pharmacist on duty to have it fixed immediately. The repair was done later on the day of the inspection.

Recommend: Civil penalty of $50 since no one could verify how long it had not been working.

Dr. Wilson made the motion to issue a Letter of Instruction to the pharmacy for not having hot water. Dr. Dickenson seconded the motion. The motion carried.

Case 15.

Complainant alleged being shorted 30 Phentermine 37.5 at respondent pharmacy. Complainant also alleged this is the second time this has happened and that the first time, the pharmacy apologized and corrected the miscount. Because of that incident, the complaint states that the patient now recounts the prescription before leaving the store, and upon noticing the shortage this time, immediately returned to the pharmacy counter but staff refused to give an additional 30 tablets. Complainant stated that his own recount was done clearly in view of store cameras and asked staff to review footage to show that only 30 pills were in the bottle.

BOP Investigator obtained a sworn statement from respondent pharmacy's PIC stating he did review camera footage but there was a 2 minute period of time when the patient is off camera. Pharmacy counts were performed and were correct. The quantity on the vial was circled indicating the medication was double counted. Video footage is no longer available. There was no record at the pharmacy of a previous report of the patient claiming to have been shorted, nor any indication that the patient was ever given 30 additional tablets previously. Patient's profile shows fill dates of 9/23/16, 10/19/16, 11/17/16, and

12/14/16. The only note in the patient's record was "Patient says he is shorted Phentermine 12/14/2016 and it is circled."

Complaint allegations could not be confirmed.

Recommend: Dismiss

Dr. Bunch made the motion to accept counsel's recommendation. Dr. Dickenson seconded the motion. The motion carried.

Case 16.

Respondent is PIC for Case 16 above.

Recommend: Dismiss

Dr. Bunch made the motion to accept counsel's recommendation. Dr. Dickenson seconded the motion. The motion carried.

Case 17.

BOP Investigator reported observations in a facility licensed as an in-state pharmacy (503a), Manufacturer, and Outsourcer as well as being an FDA 503b Outsourcer. During the observations, the facility de-registered with the FDA as a 503b Outsourcer. The PIC indicated that only patient specific prescriptions are dispensed from this facility. It dispenses about 750 prescriptions per day, Monday thru Friday, and is a closed door facility that only dispenses pellets to be implanted under the skin. All medications are sent to a third party company for sterilization (Electron Beam) before being returned to the facility for a final check and dispensing across the country. BOP investigator viewed two pharmacists on duty during operations.

- BOP investigator reviewed seven reports of pellets which were out of potency issue range. A recall was put in place for all potency issued medications and a record of completion was noted.

- An analytical balance was discovered to be in use that had an outer cracked glass. The PIC indicated that it was removed and labeled not to be used. It was also noted that there were no reports of issues occurring due to the cracked glass.

- Regarding an observation that the pharmacist did not verify the end process of the sterile compounds, the PIC indicated that this was an isolated incident and that all aspects of the process are now observed by the pharmacist and documented.

- Regarding the lack of cleaning of equipment between each batch, the pharmacy representative indicated that a procedure is being developed for cleaning of the instruments between the powder preparation batches.
- Regarding the lack of proper use of a sporicidal, the pharmacy representative indicted that the sporicidal agent policy had a typo of 5 minutes and has been updated to a dwell time of 10 minutes per the manufacturer's instructions, and will be validated at a different facility to verify the effectiveness against microorganisms.

Recommend: Reprimand for violations.

Dr. Wilson made the motion to issue a Reprimand to the pharmacy for the violations listed. Dr. Pryse seconded the motion. The motion carried.

Case 18.

Respondent was PIC for Case 18 above and resigned as PIC shortly afterwards.

Recommend: Same discipline as pharmacy

Dr. Wilson made the motion to issue a Reprimand to the PIC for the violations listed. Dr. Pryse seconded the motion. The motion carried

Case 19.

During a periodic inspection on 2/7/17, BOP Investigator discovered the hot water in the pharmacy was no working. Investigator instructed pharmacist on duty to correct this immediately. Investigator phoned the PIC on 2/10/17 and was informed the problem had not been corrected. PIC reported the problem had been corrected on 2/11/17. Pharmacy was without hot water for at least 4 days.

Recommend: $50 per day for at least 4 days = $200.00 civil penalty

Dr. Wright made the motion to issue a Letter of Instruction for not having hot water for 4 days. Dr. Bunch seconded the motion. The motion carried.

Case 20.

Respondent is PIC for Case 19 above.

Recommend: Dismiss

Dr. Bunch made the motion to accept counsel's recommendation. Dr. Wright seconded the motion. The motion carried.

Case 21.

Complaint was filed anonymously that respondent LTC/group home pharmacy only checks electronic prescriptions monthly, resulting in changed orders not being filled in a timely manner; that the pharmacy bubble packs medications resulting in higher costs to Tenncare and Medicare; that respondent pharmacy will not transfer prescriptions to competitors; that if prescriptions are transferred, respondent pharmacy "bullies" other pharmacies demanding to transfer prescriptions back to respondent pharmacy.

BOP Investigator interviewed respondent pharmacy's PIC and obtained sworn statements regarding the allegations. PIC stated that e-scripts are checked daily; that respondent pharmacy does offer customized services to help meet unique needs of those with mental illness and to ensure the patients adhere to their medication therapy; that when transfer requests are made, PIC does try to identify any service issues for the opportunity to retain the business, but if necessary, the prescription is transferred; that some of the group homes being serviced actually prefer respondent pharmacy; and that respondent pharmacy provides packaging to make medication transport, administration, and reconciliation easier (including some in traditional vials.) Investigator could find no violations.

Recommend: Dismiss

Dr. Pryse made the motion to accept counsel's recommendation. Dr. Wilson seconded the motion. The motion carried.

Case 22.

Respondent is PIC for Case 21 above.

Recommend: Dismiss

Dr. Wilson made the motion to accept counsel's recommendation. Dr. Pryse seconded the motion. The motion carried.

Case 23.

Respondent technician admitted in writing to forging and/or altering prescriptions for controlled substances for personal use. This was done in various ways including using her maiden name and creating fake profiles so that she could re-scan previously filled prescriptions. The prescriber noticed unauthorized prescriptions in CSMD and contacted the pharmacy which prompted the investigation.

Recommend: Revoke tech registration

Dr. Dickenson made the motion to authorize a formal hearing for revocation. Dr. Pryse seconded the motion. The motion carried.

Case 24.

Pharmacy management provided copies of an internal investigation and respondent technician's signed admission statement admitting diversion of controlled substances for self-medicating that led to an addiction.

DEA 106 lists the following drugs missing:

8 Alprazolam 0.25mg

7 Alprazolam 0.5mg

55 Alprazolam 1mg

168 Tramadol 50mg

25 Suboxone 8mg/2ml SL Film

175 Carisoprodol 350mg

Criminal charges are pending.

Recommend: Revoke tech registration

Dr. Wright made the motion to authorize a formal hearing for revocation. Dr. Wilson seconded the motion. The motion carried.

Case 25.

Pharmacy management provided results of an internal investigation indicating respondent technician diverted controlled substances by theft and also by creating fake prescriptions to be delivered to patients. A prescriber noticed on CSMD that some prescriptions were not authorized for certain patients. The pharmacy internal investigation revealed the prescriptions in question were filled and rang up by the same technician, supposedly for delivery, however patient interviews revealed the drugs were never delivered. Respondent denied wrongdoing and resigned immediately following the loss prevention interview. No additional losses have occurred since respondent's resignation.

BOP Investigator attempted to contact respondent twice by leaving voice messages. Respondent never replied.

Internal audit revealed 470 Alprazolam 2mg tablets missing and 3,150 tablets lost due to processing fraudulent prescriptions.

Recommend: Revoke tech registration

Dr. Dickenson made the motion to authorize a formal hearing for revocation. Dr. Wright seconded the motion. The motion carried.

Case 26.

Complaint unprofessional conduct by respondent pharmacy contacting transplant patients to have their prescriptions transferred and filled by respondent pharmacy that is affiliated with a transplant hospital. Complaint alleged aggressive marketing by respondent pharmacy.

BOP Investigator conducted interviews and gathered informational pamphlets that are provided to patients by respondent. Investigator was satisfied that respondent is not violating any laws or rules and is not being unprofessional.

Recommend: Dismiss

Dr. Wright made the motion to accept counsel's recommendation. Dr. Wilson seconded the motion. The motion carried.

Reinstatement
Amanda Clark, D.Ph.

Dr. Clark requested to have her licensed reinstated. Dr. Clark's license was revoked on 01/30/2017. After discussion, Dr. Pryse made the motion to reinstate Dr. Clark's license. Dr. Clark's license will be on five (5) year probation once she has completed all the necessary requirements for reinstatement with the following conditions. Dr. Dickenson seconded the motion. The motion carried.

(a) The Respondent shall completely abstain from the consumption of alcohol or any other drugs, except as specified in (b);

(b) The Respondent shall be able to consume legend drugs or controlled substances prescribed by the Respondent's primary physician except in the case of an emergency or upon proper referral from the Respondent's primary physician. Upon ratification of this order, the Respondent shall

immediately notify the Board office in writing of the name of the Respondent's primary care physician. The Respondent shall immediately notify the Board office in writing of the name of the Respondent's primary physician each time the Respondent changes primary physicians;

(c) The Respondent shall not obtain or attempt to obtain any prescriptions in the Respondent's name for any legend drugs, controlled substances or devices containing same from a physician other than the Respondent's primary physician or from any other health care provider, such as a nurse practitioner, physician's assistant or psychiatrist;

(d) The Respondent shall destroy any unused controlled substances prescribed under the provisions of subsection (b) no later than thirty (30) days following the completion of the prescribed course of treatment;

(e) The Respondent shall report to the Board, in writing, the ingestion of any and all legend drugs or controlled substances (a copy of the prescription will satisfy the requirement);

(f) The Respondent shall submit to random sampling of urine, blood or bodily tissues for the presence of drugs and alcohol, at the Respondent's own expense, by agents of the Board, such as the Tennessee Pharmacist Recovery Network for as long as the Respondent has an active license. In the event that the sampling indicates the presence of drugs for which the Respondent does not have a valid prescription or the sampling indicates the presence of alcohol, then formal disciplinary charges may be brought against the Respondent which could result in the revocation of the Respondent's remaining term of probation or the suspension or revocation of the Respondent's license to engage in the practice of pharmacy. Prior to such disciplinary charges being heard by the Board, the Respondent's license may be summarily suspended;

(g) The Respondent shall comply with all of the terms and conditions of the extended aftercare contract she entered into with the Tennessee Pharmacist Recovery Network. Respondent shall return a copy of said contract with this consent order to the Board Office.

(h) The Respondent shall not serve as pharmacist-in-charge for a period of three (3) years from the start date of probation; however, after a period of two (2) years' probation the respondent may petition the Board for a modification of this Consent Order to remove the restrictions upon show of good causes. The Respondent shall not work as a "floater" for a period of three (3) years, meaning that the Respondent shall not work at more than one (1) pharmacy location at the same time without permission of the Board;

(i) Respondent shall complete all provisions required for the reinstatement of his license listed in Board Rule 1140-01-.07 (3) (a):

1. Provide written notice to the board requesting an active license;
2. Satisfy all past due continuing pharmaceutical education as required by the board;
3. Pay all cumulative license renewal fees and any applicable penalty fees for the period during which the license was inactive, delinquent, suspended or revoked;

Robin Terrero, D.Ph.

Dr. Terrero requested to have her license reinstated. Dr. Terrero's license was revoked on January 28, 2015. After discussion, Dr. Pryse made the motion to deny Dr. Terrero's request for reinstatement. Dr. Dickenson seconded the motion. The motion carried.

Appearance
Better Pharmacy Practice Continuing Education

Dr. Bruce White appeared before the board to present a continuing education program for pharmacist. The course is through the Albany University Medical College in Alban, New York. It is a twenty-five (25) hour online course that will include pharmacy ethics and law. Dr. White stated that he has been in contact with the University Of Tennessee College Of Pharmacy for continuing education credits.

Fred's Pharmacy
Remote Will Call Center

Tonya Shackleford, Director of Pharmacy, appeared before the board to ask for approval to install a Script center in the Memphis Corporate Office/Distribution Center to allow for pickup of prescriptions from Fred's Pharmacy #2286 during the hours that the pharmacy is closed. After discussion, the board decided to have Dr. Denaburg to inspect the facility and report back to the board before a decision will be made.

Waiver
Board rule 1140-03-.14 (12)

Dr. Dickenson made the motion to approve the request from William Austin**, Pharm. D.**, to be pharmacist in charge for six (6) months at Priority Care Pharmacy Solutions, LLC, Priority Care pharmacy, LLC and Priority Care Pharmacy Services, LLC in Amory, MS. Dr. Pryse seconded the motion. The motion carried

Consent Orders

Mr. Gibbs presented a consent order in the name of Chris Flynn, RT, hat places his registration as a pharmacy technician on probation for 3 years. After discussion, Dr. Dickenson made the motion to accept the consent order as presented. Dr. Wilson seconded the motion. The motion carried.

Mr. Stefan Cange, Attorney for State of Tennessee, presented a consent order for Cardinal Health (Algood). Cardinal Health (Algood) violated board rule 1140-01-.02. This license has been reprimanded and will require one (1) of monitoring by an independent monitoring group approved by the executive director of the board. After discussion, Dr. Wilson made the motion to accept the consent order as presented. Dr. Wright seconded the motion. The motion carried.

Dr. Dickenson made the motion to accept the following consent orders as presented. Dr. Wilson seconded the motion. The motion carried.

PROBATION
Alexandra Barnette, D.Ph.
Chris Flynn, RT
Ashley Brown, RT

REVOCATION
Ryan Schweer, RT
Tiffany Hamlet, RT
Stacy Williams, RT

VIOLATED BOARD RULE 1140-02-.02 (1)
Kimberly Thompson, RT-$100.00 civil penalty

VIOLATED BOARD RUEL1140-9-035(2) (b) & (c)
Unity Home Medical, LLC-$750.00 civil penalty

VOLUNTARY SURRENDER (same as revocation)
Anna McCraw, RT
Palmer Payne, RT

Dr. Bunch made the motion to adjourn at 3:52 p.m. Dr. Pryse seconded the motion. The motion carried.

The minutes were approved and ratified at the June 13, 2017 board meeting.