



# Idaho Board of Pharmacy

Published to promote voluntary compliance of pharmacy and drug law.

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## ***Mick, You Will Be Missed!***

After 22 years of dedicated commitment and service to this office, it is with great sadness that we report that Richard K. "Mick" Markuson has retired as the executive director of the Idaho Board of Pharmacy.

Mick's dedication to the practice of pharmacy and his charge to protect the health, safety, and welfare of the public has been unparalleled. He has always been held in the utmost regard by his staff and fellow pharmacists. During a retirement dinner held in his honor, Board staff presented Mick with the state of Idaho's silver medallion in recognition of his service to the Board.

During Mick's tenure he also served as a member of the National Association of State Controlled Substances Authorities, the Alliance of States with Prescription Monitoring Programs, the American Society for Pharmacy Law, the Idaho State Pharmacy Association, and in 1997 was appointed an Honorary Life Member of the Idaho Society of Health-System Pharmacists.

Beginning in 1990 Mick worked on many National Association of Boards of Pharmacy® (NABP®) committees, and has chaired the Committee on Law Enforcement/Legislation and the Committee on Constitution and Bylaws. Prior to his term as president-elect, Mick was a member of the NABP Executive Committee for three years and active on numerous NABP committees and task forces. Mick graduated from North Dakota State University College of Pharmacy in 1960 and has been a licensed pharmacist in Idaho since 1962. He has received numerous awards for his contributions to the practice of pharmacy including the Wyeth-Ayerst Bowl of Hygeia Award. Mick assumed his position as chairman of the NABP Executive Committee after completing one-year terms as both president and president-elect of NABP. During his term as president, NABP signed a memorandum of understanding with Canada's National Association of Pharmacy Regulatory Authorities for the licensing of the NABP Verified Internet Pharmacy Practice Sites™ program; saw Florida begin its participation in the Electronic Licensure Transfer Program®, and joined the Pharmacy Technician Certification Board (PTCB) as a full partner and member of the PTCB Board of Governors.

Throughout his association with NABP and the Idaho Board of Pharmacy, Mick has always championed issues that truly affect the public health and welfare. Mick's support and unwavering commitment to this Board has been vital to its continued success. He will be truly missed. Although we regret Mick's departure, we wish him the very best in his new endeavors.

## ***Nicole Chopski, PharmD, New Board Member***

Governor Butch Otter recently appointed Nicole Chopski, PharmD, to serve on the Idaho Board of Pharmacy. Nicole replaces Michael Merrill who resigned his position with the Board. Nicole's first term on the Board will run until June 30, 2009.

Raised and educated in Pocatello, Nicole obtained her PharmD from Idaho State University College of Pharmacy in 1997. She immediately entered into long-term care pharmacy where she quickly became the director. Passionate about geriatric psychiatry, Nicole went on to certify nationally

as a certified geriatric pharmacist in 2002. Following a desire to be well-rounded, in 1997 she also joined the hospital pharmacy staff at then Bannock Regional Medical Center, now Portneuf Medical Center (PMC). Nicole continues to enjoy a working relationship with the hospital pharmacy staff at PMC and just celebrated her 10<sup>th</sup> anniversary as a PMC employee.

Most recently her professional interests have turned to nuclear pharmacy. Following successful completion of Purdue University College of Pharmacy's program in nuclear pharmacy, she partnered with others to open the first nuclear pharmacy in southeast Idaho. Her love and enthusiasm for pharmacy has been illustrated by her continual efforts to stay current while pushing herself to grow within the profession. She has been involved in multiple professional organizations from early on in her career. She believes that it is through leadership and involvement of the individual pharmacist that the profession of pharmacy will continue to advance and succeed. Outside of pharmacy, her interests include riding Harley-Davidson motorcycles, traveling, and auctions.

## ***Holly Henggeler, PharmD, New Board Member***

Following the resignation of Richard Jones, Governor Butch Otter has appointed Holly Henggeler, PharmD, to serve the remainder of Richard's five-year term. Holly's first term on the Board will run until June 30, 2010.

Holly graduated from Idaho State University with a doctor of pharmacy degree in 2000. Holly has worked at various Albertsons/Savon locations throughout Idaho and has been the pharmacy manager in Payette since 2001. In addition, Holly is the district pharmacy manager trainee for Albertsons/Savon's intermountain region and received Albertsons/Savon's manager of the year award in 2006. Prior to moving to Idaho, Holly received a bachelor of business administration degree from California State Polytechnic University, Pomona in 1987. She worked for Savon Drug Stores in Southern California and was promoted to general manager in 1989. Holly and her husband Kelly have twin boys, Joseph and Joshua, who are their pride and joy. Holly also enjoys reading and going to the movies with her family.

## ***Transferring Prescriptions for Controlled Substances***

A pharmacist may transfer prescription order information for the purpose of refilling a prescription only if the information is communicated orally directly by one pharmacist to another pharmacist. Such oral information may be communicated by an extern/intern under the direct supervision of a pharmacist as long as one of the parties involved in the communication is a pharmacist and the order is **not for a controlled substance**.

## ***Idaho Prescription Monitoring Program***

As of July 1, 2007, controlled substance prescription reporting is now to be done on a weekly basis. There have been problems with the labeling of disks and CDs used for controlled substance data reporting. Proper labeling should have the pharmacy name, the pharmacy Idaho license number, and the date range of data on disk/CD. The Board of Pharmacy has a file transfer protocol (FTP) server available for submitting data electronically. By using

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## **FDA Issues Guidance on Glycerin Testing to Prevent DEG Poisoning**

Spurred to action by repeated instances of diethylene glycol (DEG) poisoning, Food and Drug Administration (FDA) recently issued a guidance for industry entitled "Testing of Glycerin for Diethylene Glycol." This guidance provides recommendations on testing that will help pharmaceutical manufacturers, repackers, and other suppliers of glycerin, and pharmacists who engage in drug compounding, to avoid the use of glycerin that is contaminated with DEG and prevent incidents of DEG poisoning.

DEG contamination of glycerin can be detected by using specific analytical test procedures described in the United States Pharmacopeia monograph for glycerin, which quantifies the amount of DEG present at a detection level of 0.1%, as recommended by the interagency Diethylene Glycol Contamination Prevention Workshop of 1997. The guidance is available on the FDA Web site at [www.fda.gov/cder/guidance/7654fnl.htm](http://www.fda.gov/cder/guidance/7654fnl.htm). FDA is accepting electronic comments on the guidance at [www.fda.gov/dockets/ecomments](http://www.fda.gov/dockets/ecomments).

## **Improperly Compounded Colchicine Blamed for Recent Deaths**

Compounded colchicine that was 10 times as potent as labeled was responsible for two recent deaths in Oregon and Washington, the *Portland Tribune* reported on April 27, 2007. State officials are investigating the drug's role in a third death, also in Oregon. The drug was sent to a Portland, OR, clinic by ApothéCure, Inc, a Dallas, TX-based compounding pharmacy that distributes its drugs throughout the country. The two patients who died had received injections of colchicine as a treatment for back pain. Lab tests revealed that the colchicine administered in the two deaths had a potency of 4 mg/ml, rather than the 0.5 mg/ml stated on labels. According to Gary A. Schnabel, executive director of the Oregon State Board of Pharmacy, ApothéCure, a licensed Texas pharmacy, may be operating as a manufacturer. Both the Oregon Board and the Texas State Board of Pharmacy have opened investigations into the incident. The Texas Board advised ApothéCure to stop making colchicine; the company agreed, the *Portland Tribune* reported. On May 2, FDA announced the recall of all strengths, sizes, and lots of injectable colchicine compounded and sold by ApothéCure within the last year. The FDA MedWatch Safety summary on this issue is available at [www.fda.gov/medwatch/safety/2007/safety07.htm#Colchicine](http://www.fda.gov/medwatch/safety/2007/safety07.htm#Colchicine).

## **New Podcasts Provide Emerging Drug Safety Information**

FDA recently supplemented its print- and Web-based public health advisories with the launch of an audio broadcast service providing emerging drug safety information. The broadcasts, commonly known as podcasts, can be transmitted to personal computers and personal audio players. The service is part of FDA's ongoing effort to broaden and speed its communications on the safety of marketed medications when unexpected adverse events are reported to FDA. Since FDA launched the service in February 2007, broadcasts have addressed the potential hazards

of local anesthetics used in hair removal; the voluntary market withdrawals of drugs to treat the symptoms of Parkinson's disease and irritable bowel syndrome; and serious adverse events associated with agents that reduce the need for blood transfusions in cancer patients. The broadcasts are available on the FDA Web site at [www.fda.gov/cder/drug/podcast/default.htm](http://www.fda.gov/cder/drug/podcast/default.htm).

## **Prevent Tragedies Caused by Syringe Tip Caps**



*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](http://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](mailto:ismpinfo@ismp.org).*

Over the past several years, there have been a number of reports where children have swallowed or choked on hypodermic syringe caps that were overlooked by parents and left on the syringes administering the medication. In 2001, a 5-month-old child asphyxiated when a cap from a Becton Dickinson 3 ml hypodermic syringe ejected into his throat during medication administration. In this case, a pediatrician provided the parents with the hypodermic syringe (without the needle) to administer Vantin<sup>®</sup> (cefepodoxime) suspension. With the cap intact, the father inserted the syringe into the Vantin, pulled back the plunger, and the medication flowed into the syringe. To him, the cap appeared to be part of the syringe. When he placed the syringe containing the medication into the baby's mouth, the cap flew off and became lodged in his airway. The baby was taken to the hospital where a procedure was performed to remove the cap; however, he did not survive.

Despite these reports, the mother of a 9-month-old child recently notified the Institute for Safe Medication Practices about a near fatal experience involving her child. Her community pharmacist gave her a parenteral syringe (without the needle) to help her accurately measure and administer an oral rehydration liquid for her daughter. Unfortunately, the pharmacist's good intention resulted in patient harm. The mother was unaware that the syringe tip held a small, translucent cap; however, despite this, she was able to withdraw the oral liquid. Then as she administered the liquid, the cap on the end of the syringe ejected and became lodged in the child's throat, causing airway obstruction. Fortunately, the child recovered.

Although parenteral syringes are not designed for oral administration, health care practitioners may provide them to patients or caregivers to measure oral liquids without realizing how dangerous this practice may be. Some syringe



manufacturers place the small, translucent caps on parenteral syringes packaged without needles as a protective cover. However, practitioners may not realize the cap is there or may not inform patients or caregivers of the need for its removal prior to use. The danger arises due to the fact that the cap does not provide a good seal. Subsequently, medications can be drawn into many of these syringes without removing the caps. If not removed before administration, the force of pushing the plunger can eject the cap and cause it to lodge in a child's trachea.

**Safe practice recommendations:** Consider the following strategies to help protect your patients from tragedies caused by syringe tip caps.

- ◆ **Increase awareness.** Share this and previous errors with staff to illustrate why parenteral syringes should never be used for oral liquid medications. Show staff a video from FDA and ISMP highlighting this issue (access the video link at: [www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/transcript.cfm?show=3#6](http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/transcript.cfm?show=3#6)).
- ◆ **Product availability.** Ensure that oral syringes (without caps) or other appropriate measuring devices are readily available for distribution or purchase at your practice site. Verify that the dosage can be accurately measured using the oral syringe. It may be necessary to keep a few different sizes on hand to ensure proper measurement of smaller doses.
- ◆ **Limit access.** If parenteral syringes must be stocked for use with injectable products, purchase syringes that are not packaged with the translucent caps to minimize the likelihood of this error.
- ◆ **Warning labels.** Add warning labels that state, "not for use with oral liquids" to boxes or storage bins containing parenteral syringes.
- ◆ **Educate patients and caregivers.** Provide education to patients and caregivers regarding proper use of an oral syringe (or other measuring device). Demonstrate how to measure and administer the dose and inform them about how to clean the device, if it is to be reused. Several years ago, Becton Dickinson voluntarily elected to package parenteral syringes without the small caps in response to this serious issue. However, since some manufacturers still include a cap on parenteral syringes, the danger of asphyxiation with the cap is still present. We have again contacted FDA to alert them about this problem. They have stated that they will be following up with each syringe manufacturer with the goal to get the syringe caps removed. At the very minimum, we believe that the packaging of parenteral syringes should be required to clearly state, "not for oral use" or "not for use with oral liquids."

## **New FDA Web Page Warns Against Buying Isotretinoin Online**

FDA has launched a special Web page to warn consumers about the dangers of buying isotretinoin online. Improperly used, isotretinoin can cause severe side effects, including birth defects and serious mental health problems. The Web page, [www.fda.gov/buyonline/accutane](http://www.fda.gov/buyonline/accutane), is positioned as a search result on Internet search engines when consumers initiate an online search for the drug under any one of its four names (isotretinoin is sold under the brand name of Accutane® and in generic versions called

Amnesteem™, Claravis™, and Sotret®). The Web page warns that the drug "should only be taken under the close supervision" of a physician and a pharmacist, and provides links to related information, including ways to check that drugs purchased online come from legitimate pharmacies.

To reduce risks, FDA and the manufacturers of isotretinoin have implemented a strict distribution program called iPLEDGE to ensure that women using isotretinoin do not become pregnant, and that women who are pregnant do not use isotretinoin. Isotretinoin is available only at pharmacies that are registered for this distribution program. Additionally, the distribution program is designed to prevent the sale of isotretinoin over the Internet. Dispensing must comply with the agency's risk management requirements.

## **Tampering Results in Misbranding of Ziagen as Combivir**

GlaxoSmithKline and FDA warned health care professionals of an apparent third-party tampering that resulted in the misbranding of Ziagen® as Combivir® and employed counterfeit labels for Combivir tablets. Two 60-count misbranded bottles of Combivir tablets contained 300 mg tablets of Ziagen.

The counterfeit labels identified are Lot No. 6ZP9760 with expiration dates of April 2010 and April 2009. The incident appears to be isolated and limited in scope to one pharmacy in California.

Pharmacists are advised to immediately examine the contents of each bottle of Combivir in their pharmacies to confirm that the bottles contain the correct medication. If a bottle contains anything other than Combivir tablets, pharmacists are advised to notify the manufacturer.

The letter from GlaxoSmithKline and FDA, containing photos of actual Combivir and Ziagen tablets, is posted on the FDA Web site at [www.fda.gov/medwatch/safety/2007/Ziagen\\_Dear\\_RPh\\_03-29-2007.pdf](http://www.fda.gov/medwatch/safety/2007/Ziagen_Dear_RPh_03-29-2007.pdf).

## **FDA Issues Halt on Manufacture, Distribution of Unapproved Suppository Drugs**

FDA notified health care professionals and consumers that companies must stop manufacturing and distributing unapproved suppository drug products containing trimethobenzamide hydrochloride.

These products, used to treat nausea and vomiting in adults and children, have been marketed under various names, including Tigan®, Tebamide™, T-Gen, Trimazide, and Trimethobenz. Drugs containing trimethobenzamide in suppository form lack evidence of effectiveness. This action does not affect oral capsules and injectable products containing trimethobenzamide that have been approved by FDA.

FDA urges consumers currently using trimethobenzamide suppositories or who have questions or concerns to contact their health care professionals. Alternative products approved to effectively treat nausea and vomiting are available in a variety of forms.

The MedWatch safety summary and a link to the full press release are available at [www.fda.gov/medwatch/safety/2007/safety07.htm#trimethobenzamide](http://www.fda.gov/medwatch/safety/2007/safety07.htm#trimethobenzamide).

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the FTP server to report, you do away with disks or CDs all together. There are a few pharmacies reporting non-controlled substance prescriptions. Please check your programs to see that only controlled substance (Schedules II, III, and IV) prescriptions are being reported. You should not be reporting Soma<sup>®</sup>/carisoprodol or tramadol/ Ultram<sup>®</sup>/ Ultracet<sup>™</sup>.

There is 24/7 online access to the prescription data currently under development. This program will allow authorized individuals to access controlled substance prescription information at the Board office on a 24/7 basis. Individuals wishing to use this program will be required to submit an application to the Idaho Board of Pharmacy for verification. The Board anticipates that this program will be available by fall 2007. There will be more information available as a release date gets closer.

The number of prescription profile requests has increased tremendously. As a result, the turn around time for a prescription profile report has increased. To help expedite the process and get a quicker return, make sure that the request form is complete and legible and that all requests are signed by a **pharmacist or practitioner**. If you have questions regarding the Prescription Monitoring Program please contact Teresa Anderson at the Board office at 208/334-2356.

## Pharmacy Technician Registration Questions

### 1. What are the requirements to register as a pharmacy technician?

- Idaho does not **require** training prior to becoming a pharmacy technician.
- The Idaho Board of Pharmacy does not recognize certification or pharmacy technician licenses/registrations from other states.
- The only requirement is that an applicant first secure employment with a pharmacy in Idaho (this includes volunteers and pharmacy technician students).
- Once employment is secured the applicant must complete a new Pharmacy Technician Registration Application. Applications are only available through the pharmacy. The pharmacist-in-charge (PIC) must sign the application. Only the PIC and the technician completing the form are allowed to sign the application.

- ◆ Applications can take up to five business days to process. There is a credit card transmittal form on the Board Web site at [www.state.id.us/bop](http://www.state.id.us/bop). Fax the completed credit card form and application to 208/334-3536 to shorten processing time.

### 2. What happens when pharmacy technicians quit or leave the pharmacy?

- When a pharmacy technician leaves your pharmacy for any reason, notify our office by fax or mail and indicate the date that employment

was terminated. If there are additional reasons for dismissal such as a theft or loss, those must be reported to the Board as well.

### 3. What about additional work locations or a change in work location?

- We must know where the pharmacy technicians are working at all times.
- If they are at an additional work location including a chain (ie, Fred Meyer or Savon), we must have an additional work location form **for each site at which the technician is currently working**. There are no additional fees required for additional work locations, but the forms must contain the signatures of both the pharmacist and the technician completing the form.
- There is no additional fee for change of work locations. These forms are to be submitted and signed by the technician and the PIC. The PIC is the only pharmacy personnel allowed to sign the form in addition to the technician completing the form.

### 4. What if I need to reinstate my pharmacy technician registration?

- When a technician who has been working in the pharmacy pays for his or her registration **after** July 31 of each year, a reinstatement application must be completed and submitted along with a late fee for a total of \$52.50. The reinstatement application is the same as a new application. A technician who is reinstating may **not work** in the pharmacy until his or her current registration is posted by the pharmacy.

### Special Notice

The *Idaho Board of Pharmacy Newsletter* is considered an official method of notification to pharmacies, pharmacists, pharmacy intern/externs, and pharmacy technicians registered/licensed by the Board. Please read them carefully. We encourage you to keep them filed in your pharmacy, preferably in your Idaho Pharmacy Law book, for future reference.

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