



DRUGS, DRUGS, & MORE DRUGS

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Duties of the Ohio Board of Pharmacy

- **Licensing/Administrative Agency**
- **Law Enforcement Agency**

Enforcement Responsibility – ORC Chapters

2925. – Criminal Drug Laws

3715. – Food & Drug Laws

3719. – Controlled Substance Laws

4729. – Pharmacy/Dangerous Drug Laws

PRESENTATION OBJECTIVES

1. Discuss R.Ph. duties & responsibilities when presented with an RX for dispensing
2. Discuss the problem with drugs from an individual state perspective





PRE-TEST ?????? #1

1. A Pharmacist must:
 - a. Fill any RX presented w/o question
 - b. Use independent judgment on **EVERY** RX presented
 - c. Question only those RXs where a definite allergy or overdose exists



PRE-TEST ?????? #2

2. A prescription for oxycodone 30mg #240 written yesterday in Albany, NY for a patient from Hartford, CT who drove to Boston to pick up the RX is obviously for a legitimate medical purpose and should not be questioned:
 - a. True
 - b. False

PRE-TEST ?????? #3

3. There is a legitimate medical reason for the combination of an opiate, a benzodiazepine, and carisoprodol to be prescribed to one person

- a. True
- b. False





PHARMACY'S TWO MOST IMPORTANT RULES FOR PRACTICE



**MOST IMPORTANT RULE FOR
PRACTICE**

**ALWAYS, ALWAYS,
ALWAYS ACT IN
THE BEST
INTERESTS OF
YOUR PATIENT**



**MOST IMPORTANT RULE FOR
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BEST INTERESTS OF
YOUR PATIENT**

**Sometimes, that means
saying “NO”**



AND RULE #2 IS?

4729-5-21 OAC & 1306.04 CFR

(A) A prescription, to be valid, must be issued for a legitimate medical purpose by an individual prescriber acting in the usual course of his/her professional practice. The responsibility for the proper prescribing is upon the prescriber, but a corresponding responsibility rests with the pharmacist who dispenses the prescription. An order purporting to be a prescription issued not in the usual course of bona fide treatment of a patient is not a prescription and the person knowingly dispensing such a purported prescription, as well as the person issuing it, shall be subject to the penalties of law.



CASE STUDY ON CORRESPONDING RESPONSIBILITY

**IS THERE A
PRESCRIPTION DRUG
PROBLEM?**

YOU BE THE JUDGE -



The 16,651 opiate overdose deaths in the U.S. in 2010 is equivalent to an MD80 aircraft carrying 140 passengers crashing **EVERY DAY for 4 straight months!**

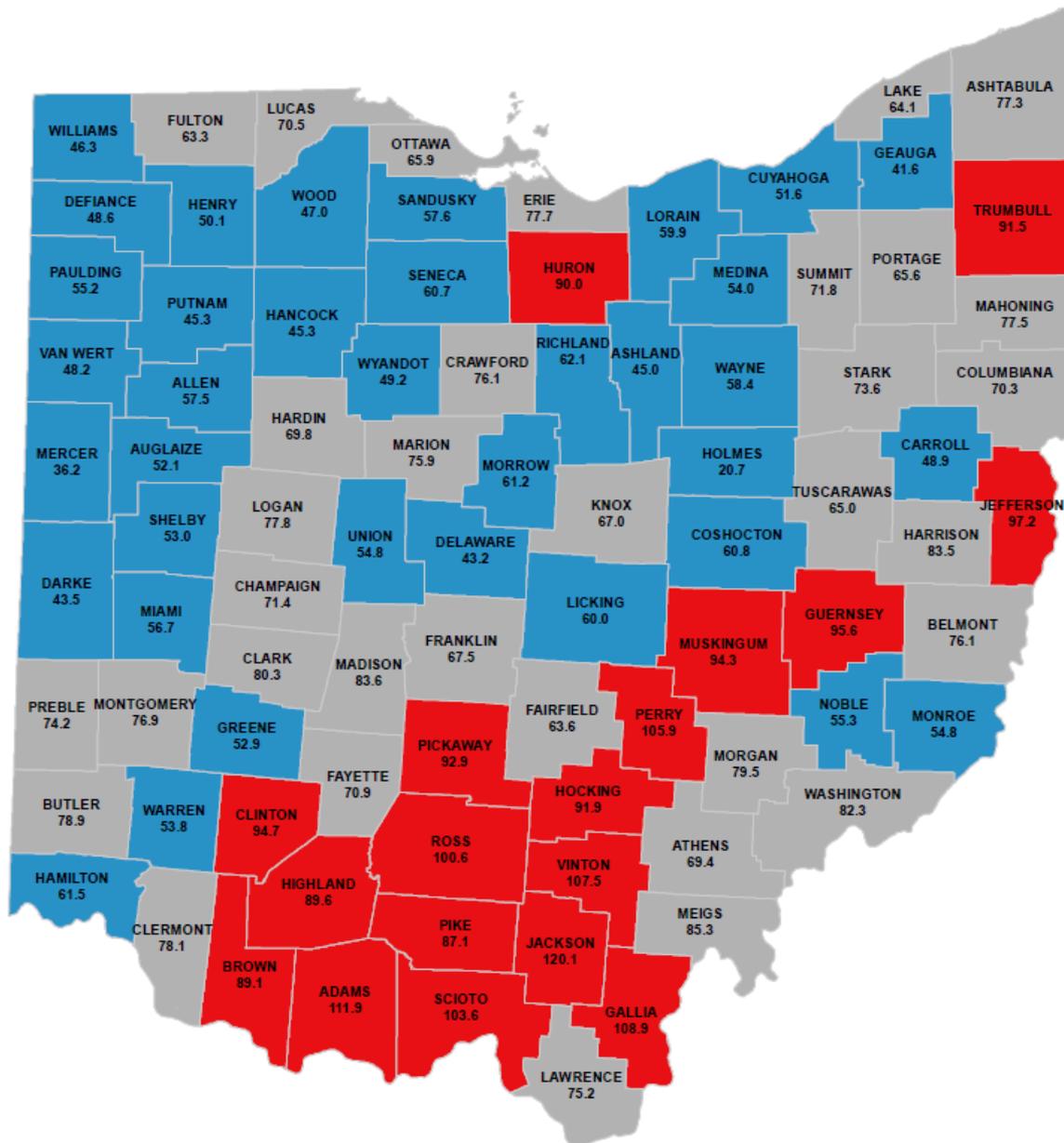


OARRS TOP TEN DRUGS 2012

DRUG	# DOSAGE UNITS	2011-2012 %CHANGE	PER CAPITA AVERAGE
HYDROCODONE	288,916,417	-1.4%	25
OXYCODONE	259,859,420	5.2%	23
TRAMADOL	163,532,246	10.7%	14
ALPRAZOLAM	128,018,592	1.2%	11
LORAZEPAM	73,281,529	2.9%	6
PREGABALIN	71,352,325	48.6%	6
CLONAZEPAM	64,176,546	5.5%	6
AMPHETAMINE	55,462,943	32.6%	5
ZOLPIDEM	48,588,443	3.4%	4
METHYLPHENIDATE	44,778,675	30.5%	4

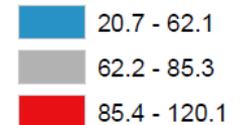


Prescription Opioid Doses Per Capita - 2011



Legend

Doses per Capita



Data Source:
Data adapted from the
Ohio State Board of Pharmacy
Map produced March 2012

Map Information:

This map represents the doses of prescription opioids available for each person during 2011. Ohio's average per capita rate is 66.7 doses. The counties with the highest per capita rates were Jackson (120.1), Adams (111.9) and Gallia (108.9). The counties with the lowest per capita rates were Holmes (20.7), Mercer (36.2) and Geauga (41.6).

WHAT ABOUT THE “TRINITY”

- Is there any legitimate reason to prescribe/dispense an opiate, a benzodiazepine, and carisoprodol to one individual?
- Not if you know their indications and metabolism, there isn't!



PILL MILLS –OHIO

CASE STUDY ABOUT AN OHIO
DOCTOR:





HOSPITAL PHARMACY DIVERSION

CASE STUDY ABOUT AN OHIO
PHARMACIST STEALING DRUGS
FROM THE PHARMACY



WHAT DID HE DO?

- Large teaching hospital for children
- Large pharmacy staff
- Director of Pharmacy was mostly a manager, very little staff work
- Narcotic room supervised by upper level staff R.Ph.



WHAT DID HE DO?

- Narcotic room used CII Safe program
- Fingerprint readers for all disbursements from narcotic room.
- Supervisory R.Ph. in Narc Room assigned all fingerprints.

WHAT DID HE DO?

- This R.Ph. stole large quantities of controlled substances before being caught.



HOW DID HE DO IT?

- **Very simple:**
- **He assigned one of his fingers as belonging to the Director of Pharmacy, knowing that the Director did not ever remove drugs from the room.**





WHAT HAPPENED?

- He finally got caught when another ALERT staff R.Ph. noticed that the Director was “removing” narcs from the room and knew that was unusual – particularly in those quantities.
- Initial concern was that the Director was the problem, which made R.Ph. & Board investigator concerned.

END RESULT

- **Director interviewed by Board agent and determined to be unaware of shortages.**
- **Further investigation led to guilty R.Ph. who then confessed and was sanctioned by the Board.**
- **Bodily harm to R.Ph. by Director nearly occurred!**





FINAL COMMENTS

- **Even a trusted staff member can be vulnerable to drugs.**
- **TRUST BUT VERIFY**
- **Suggestion – 2 people to assign access to secure programs & locations**
- **2 people to witness destruction & returns**
- **Routinely monitor.**



FINAL COMMENTS

- **Nurses and physicians are equally likely to be involved in diversion from floor stock supplies.**
- **In fact, if you think there isn't any diversion in your hospital, you are sadly mistaken.**
- **The same 2 person & monitoring suggestions apply here as well.**



WHO DECIDES THE VALIDITY OF PRESCRIPTIONS?

**DISPENSING PHARMACISTS NEED
TO REMEMBER THAT THEY, NOT
THEIR DISTRICT SUPERVISORS
OR MANAGERS, HAVE BEEN
ASSIGNED THE
“CORRESPONDING
RESPONSIBILITY”!!!**

HOW CAN I GET MORE INFO?

- IF THE PATIENT IS NOT FROM YOUR AREA, QUESTION WHY THEY ARE THERE. IT MAY BE LEGITIMATE – BUT.....
- TALK TO THE PATIENT
- TRUST YOUR INSTINCTS
- USE YOUR STATE PMP– AND MAYBE THERE WILL BE SOMETHING EXTRA FOR YOUR USE FROM NABP.







**FINAL
REMINDER-**



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PRACTICE**

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BEST INTERESTS OF
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I'M DONE!

