March 2014

Iowa Board of Pharmacy News

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Prescription Monitoring Program Update

As of December 31, 2013, 4,496 prescribers have registered to use the prescription monitoring program (an increase of 19% from one year ago) and 2,081 pharmacists have registered to use the program (an increase of 23% from one year ago). Between January 1, 2013 and December 31, 2013, a total of 178,226 requests for data were submitted to the program (an increase of 52% from one year ago). The program has registered 423 practitioner agents. The program is continuing to reduce the incidence of patients who utilize multiple pharmacies and multiple prescribers to obtain controlled substances (CS) in Iowa. The number of patients filling prescriptions for Schedule II, III, and IV CS and utilizing five or more prescribers or pharmacists has fallen from 3,293 in 2009, to 371 in 2013 (a decrease of 89%). In the past five years, the number of doses of CS dispensed to patients in Iowa has grown 14%, from 228,149,732 doses in 2009, to 260,092,453 doses in 2013.

Joint Position Statement on Telepharmacy in Iowa

Iowa pharmacy stakeholders, including the Iowa Pharmacy Association, the Iowa Board of Pharmacy, the University of Iowa College of Pharmacy, and Drake University College of Pharmacy and Health Sciences, released the following position statement on telepharmacy on January 16, 2014.

1. The Iowa Pharmacy Association has adopted policies on telepharmacy practice and the Board has adopted administrative rules that currently allow telepharmacy in both hospital and community practice settings.
2. The Board has granted waivers of current telepharmacy rules to sites that provide medications without the use of automated medication distribution systems.
3. The Board has granted pilot projects to additional sites to further explore and study other applications of telepharmacy.
4. The waivers and pilot projects will continue under the purview of the Board, and data from these sites performing telepharmacy services will be collected and analyzed.
5. The waivers and pilot projects are providing valuable information on medication access and patient safety in alternative drug delivery models.
6. The waivers and pilot projects will proceed over the next few years and allow the profession to develop "best practices" for telepharmacy.
7. The Iowa Pharmacy Association and the Board have established an ongoing task force to develop standards for the practice of telepharmacy in Iowa.
8. The telepharmacy task force will review the results of the waivers and pilot projects and will develop guiding principles to direct future rulemaking and legislative efforts.
9. The practice of telepharmacy presents both opportunities and risks for patients in Iowa. A thoughtful and deliberative process is needed to maximize patient safety and to allow appropriate medication access in all practice settings while maintaining the integral role of the pharmacist in the health care delivery system.

Joint Task Force on Telepharmacy

The Iowa Pharmacy Association and the Board have formed a new task force on telepharmacy that will be meeting throughout calendar year 2014. The members of the task force are Brett Barker, NuCara Pharmacy; Mike Brownlee, University of Iowa Hospitals and Clinics; Renae Chesnut, Drake University College of Pharmacy and Health Sciences; Michele Evink, Clarke County Hospital; Ryan Frerichs, Meyer Pharmacy; Susan Frey, Hy-Vee, Inc

Continued on page 4

Changes to Fentanyl Pain Patch Warnings Required by FDA

To reduce the risk of accidental exposure, Food and Drug Administration (FDA) has announced new requirements that change the appearance of fentanyl pain patch warnings to make them more visible. The change also requires new language in the warning that emphasizes the risk of death from accidental exposure, particularly in children. The announcement coincided with a Consumer Update that stressed the potential danger of improperly discarded fentanyl patches to children and pets. FDA reminded consumers of the agency's previous advice for securely storing unused patches and disposing of used fentanyl patches by folding the sticky sides together and then flushing them down the toilet. The agency also advises patients to cover in-use patches with an adhesive film to keep them from coming loose, and to regularly check patches to ensure they are securely in place. FDA offers additional information for health care providers on the "Fentanyl Transdermal System (marketed as Duragesic) Information" page, available at *www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm114961.htm*. Consumer information about safe drug disposal methods is also available on the AWAR$_X$E® Web site at *www.AWARERX.ORG*.

New: Free ISMP Medication Safety Alert! Newsletter for LTC Facilities

This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency and federally certified patient safety organization 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 an 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.*

In July, ISMP began publishing *Long-Term Care Advise-ERR,* a new *ISMP Medication Safety Alert!* newsletter for nurses and administrators in long-term care (LTC) facilities. ISMP receives error reports that have occurred in LTC facilities. The newsletter is provided free to LTC facilities in the United States thanks in part to corporate sponsorship from Lilly and for a nominal subscription fee for pharmacies that service LTC facilities and others. Please visit ISMP's Web site at *www.ismp.org/Newsletters/longtermcare* for more information, and let your LTC facilities know about this free offer.

Here are a few excerpts from a recent issue.

Immediate Vs Extended Release Error

A physician called a LTC facility to change a resident's oxycodone order from an extended-release formulation to an immediate release formulation at the same dose and frequency. The nurse receiving the verbal order transcribed it as "Discontinue OxyContin 10 mg BID, Start OxyContin 10 mg IR BID," with "IR" meant to represent immediate release. Although Oxy**Contin**® is a brand of oxy**codone,** it is only available as an extended-release tablet. The pharmacy had previously been dispensing Oxy**Contin** for the resident, so the nurse thought she could communicate the prescriber's order by discontinuing the current Oxy**Contin** order and then ordering Oxy**Contin** as an immediate-release product. The pharmacy continued dispensing Oxy**Contin.** The differences between these products and formulations were brought to the attention of nursing staff via an in-service. To minimize the risk of confusion, do not attach modifiers such as "IR" for immediate-release or "RS" for regular strength unless it is part of the official drug name.

Errors Occur During Transitions of Care

A pharmacist reported the following hazardous situation that can occur during a hospital to LTC transfer. Residents are often admitted to a LTC facility with a list of medications printed from the hospital pharmacy computer. On these printouts, doses are expressed along with the number of tablets. For example, the printout may list hydrochlorothiazide 50 mg/2 tablets daily for an order in which the total dose was 50 mg because the hospital only stocks the 25 mg tablets. During hospitalization the patient required two tablets for each dose; however, the LTC nurse may misinterpret the order to mean two 50 mg tablets, making the total dose 100 mg, or two times more than prescribed. This issue arises every time the resident's total dose in the hospital requires more than one tablet or capsule. Discharge medication summaries and transfer orders should only list the total dose in mg or mcg and other directions for use (ie, frequency, route, drug name) to avoid misinterpretation.

2013 USP Chapter <797> Compliance Survey Shows Compliance Trends Unchanged From 2012

The 2013 United States Pharmacopoeia (USP) Chapter <797> Compliance Survey, the third annual report released since 2011, shows that the overall compliance rate of 77.2% remains nearly unchanged from the 2012 rate. Budgetary restrictions and physical plant limitations were among the top challenges to compliance by survey respondents. The report also details the

survey's findings on what types of facilities are participating in compounding, and compliance in specific domain areas such as environmental sampling and gloved fingertip sampling. Of the survey's 1,045 participants, 97% of the survey's respondents said that USP Chapter <797> "has had a positive influence on patient safety." The report notes National Association of Boards of Pharmacy® (NABP®) efforts to assist state boards of pharmacy in evaluating pharmacy compliance with USP Chapter <797> requirements for sterile compounding in their states. The report also noted that those who participated in the 2011 survey had a higher compliance score than those who did not. The survey's authors encouraged pharmacy owners with multiple areas of noncompliance to target one or two areas to improve. They also encouraged organizations that participated in the survey to make use of the free Action Plan – generated upon completion of the survey – and other free resources to "reshape" their sterile compounding practices. The full report on the survey's results is available in the October 2013 issue of *Pharmacy Purchasing & Products Magazine* and on the magazine's Web site at *www.pppmag.com/article/1403*.

FDA Recommends Schedule II Classification for Hydrocodone Combination Products

FDA planned to submit a formal recommendation to reclassify hydrocodone combination products as Schedule II controlled substances to the Department of Health and Human Services by early December 2013. FDA expects the National Institute on Drug Abuse to concur with the recommendation, indicates a statement on the FDA Web site. FDA also indicates that while "the value of and access to these drugs has been a consistent source of public debate," the agency has "been challenged with determining how to balance the need to ensure continued access to those patients who rely on continuous pain relief while addressing the ongoing concerns about abuse and misuse." Drug Enforcement Administration makes the final decision about the appropriate scheduling of these drugs. In January 2013, FDA's Drug Safety and Risk Management Advisory Committee made a recommendation that hydrocodone combination products be classified as Schedule II drugs following a 19-to-10 vote that concluded a two-day meeting during which members discussed the potential for abuse and misuse of the medications and the potential impact of rescheduling the drug products. FDA's statement on the recommendation is available at *www.fda.gov/Drugs/DrugSafety/ucm372089.htm*.

New FDA Drug Info Rounds Training Videos Available

FDA Drug Info Rounds, a series of online videos, provides important and timely drug information to practicing clinical and community pharmacists so they can help patients make better medication decisions. In the latest two Drug Info Rounds videos, pharmacists discuss the review and approval of new drug names and the review of marketing and advertising materials for new drugs. The videos can be viewed at *www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm368620.htm* and *www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm371785.htm,* respectively. Drug Info Rounds is developed with contributions from pharmacists in FDA's Center for Drug Evaluation and Research, Office of Communications, and Division of Drug Information.

CPPA Developing Specialty Pharmacy Accreditation Program

The Center for Pharmacy Practice Accreditation® (CPPA) has announced the development of a new accreditation program for specialty pharmacy practices. CPPA Executive Director Lynnae Mahaney, MBA, RPh, FASHP, VHA-CM, indicates that "CPPA will be able to develop the new specialty pharmacy standards quickly and efficiently with the existing standards development methodology, infrastructure, and network of specialty pharmacy expertise."

CPPA is a partnership between the American Pharmacists Association, the American Society of Health-System Pharmacists, and NABP. CPPA develops and implements comprehensive programs of pharmacy practice site accreditation, including the promotion, development, and maintenance of principles, policies, and standards. CPPA offers the general public and users of pharmacy services a means of identifying those pharmacies that satisfy the accreditation criteria and are focused on advancing patient care, safety, and quality.

More information may be found in the press release, available at *www.pharmacypracticeaccredit.org/news/2013/10/cppa-to-develop-specialty-pharmacy-accreditation-program*.

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Continued from page 1

(member, Board of Pharmacy); Felix Gallagher, PharmServ Solutions; Randy McDonough, Towncrest Pharmacy; Jim Miller, Mercy Family Pharmacy (member, Board of Pharmacy); John Swegle, Mercy Medical Center; Judy Trumpy (public member, Board of Pharmacy); and Sam Zoske, Medicap/Beans Pharmacy.

50-Year Pharmacists

The Board congratulates the following 18 Iowa pharmacists who were originally licensed in 1964, have continuously maintained their Iowa pharmacist license, and have devoted a half-century of service to the public and the profession:

- Donald L. Avise, West Des Moines, IA
- Jean C. Abrahamson, Edmond, OK
- John T. Capper, Parnell, IA
- Bernard J. Cremers, Iowa City, IA
- Dennis D. Dobesh, Newton, IA (retired Board compliance officer)
- Harvey J. Eernisse, Fort Dodge, IA
- Louis P. Gaffney, Sioux Falls, SD
- Jack A. Gile, North Ft Myers, FL
- Alan J. Henricks, Dubuque, IA
- Russell C. Imboden, Huntersville, NC
- Gary L. Jones, Ottumwa, IA
- Dennis D. Killion, Red Oak, IA
- Thomas C. Lehman, Carroll, IA
- Paul J. Miller, Chico, CA
- Charles E. Nigut, Des Moines, IA
- William H. Reimer, Elkader, IA
- Jerome Schweitzer, Bedford, IA
- John A. Susich, Las Vegas, NV

Next Board Meeting

The Board plans to hold its next meeting on March 11-12, 2014. Administrative hearings and a closed session will be held at the Board office in Des Moines on March 11. The Board plans to meet in open session on March 12. Please contact the Board office at 515/281-5944 to confirm times and locations.

Board Website

Please visit the Board's website at *www.state.ia.us/ibpe/.*

Board Mission

The Iowa Board of Pharmacy promotes, preserves, and protects the public health, safety, and welfare through the effective regulation of the practice of pharmacy and the licensing of pharmacies, pharmacists, and others engaged in the sale, delivery, or distribution of prescription drugs and devices. Iowa Code §155A.2(1).

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& Executive Editor

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Rx TLC

Talk Lock Connect

Prevent medicine misuse in Iowa.

February 2014

Dear Iowa Health Care Professional:

The *Iowa Medicine TLC* project, in partnership with the Iowa Substance Abuse Information Center, Governor's Office of Drug Control Policy, and the Iowa Prescription Abuse Reduction Task Force, requests your assistance to prevent the misuse of prescription medicines.

Due in large part to you and other conscientious health care professionals, Iowa has the nation's lowest rate of past year prescription pain reliever abuse. However, we also know prescription drug abuse is the fastest growing form of substance abuse in our state, threatening the well-being of an increasing number of Iowans. *Iowa Medicine TLC* wants to help you continue to educate and empower Iowans to avoid this dangerous behavior.

The *"TLC"* in our name stands for **Talk**, **Lock,** and **Connect.** We developed an info-card to help Iowans understand how they can practice *TLC* to prevent medicine misuse at home. Feel free to refer patients to IowaMedicineTLC.org for this and other important information.

For a free supply of *Iowa Medicine TLC* cards that you can give to patients, please contact the Iowa Substance Abuse Information Center toll-free at 866/242-4111.

Finally, we hope you find Iowa's Prescription Monitoring Program (PMP) helpful in coordinating patient use of controlled prescription drugs, to enhance patient care and prevent the diversion or misuse of medications. For more information, go to the Iowa Pharmacy Board's PMP website at http://www.state.ia.us/ibpe/pmp/pmp-info.html or call 515/281-5944.

Thanks in advance for your participation in *Iowa Medicine TLC*, and for your ongoing efforts to promote the health and safety of Iowans!

Sincerely,

Emily J. Blomme
Iowa Medicine TLC

Steven F. Lukan
Governor's Office of Drug Control Policy

Iowa Medicine TLC is sponsored by the Governor's Office of Drug Control Policy and administered by the Iowa Substance Abuse Information Center, a program funded by the Iowa Department of Public Health