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North Carolina Board of Pharmacy

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Item 2140 – Compounding Issues

North Carolina Board of Pharmacy staff members are aware that several pharmacies, both in-state and out-of-state, regularly engage in the compounding of prescription veterinary drug products for resale. This practice plainly violates North Carolina law, which states that "[c]ompounded drug products shall not be offered to other entities for resale." 21 NCAC 46.1810(1). The Board is investigating this behavior and, where appropriate, taking disciplinary action.

Compounders are also reminded that, in a recent disciplinary action concerning the resale of compounded prescription drugs, the Board has ruled that negligence in the practice of pharmacy can result from a pharmacist's failure to take **affirmative** steps to determine whether compounded products are being resold. The Board further stated that it "recognized that compounding pharmacists can, and do, provide valuable services to patients. But with the ability to compound medications for patients comes a tremendous responsibility to ensure that these products are safe and used appropriately. Where . . . facts and circumstances should have alerted a pharmacist that compounded products [a]re not being used appropriately, that responsibility extends beyond the pharmacy counter."

Board staff is also aware that a handful of out-of-state pharmacies lacking North Carolina permits have regularly shipped compounded products (human and veterinary) into the state. A recent investigation of one such pharmacy has resulted in its discontinuing business in North Carolina. North Carolina law is clear that "out-of-state pharmacies that ship, mail, or deliver in any manner a dispensed legend drug into this State" must have an out-of-state pharmacy permit. 21 NCAC 46.1607(a). The shipping of compounded products into the state may also run afoul of wholesaler statutes and regulations. There is no "exception" to the permit requirement for compounded products, nor has there ever been any such exception.

Item 2141 – Internet Pharmacy Rule Now Effective

Effective April 1, 2007, pharmacies that satisfy the definition of an "Internet pharmacy" must comply with substantial new requirements to receive or renew a pharmacy permit.

21 NCAC 46.1317 defines an "Internet Pharmacy" as follows:

(a) A pharmacy that maintains an Internet web site for the purpose of selling or distributing prescription drugs; or

(b) A pharmacy that uses the Internet, either itself, or through agreement with a third party, to communicate with or obtain information from patients; uses such communication or information, in whole or in part, to solicit, fill or refill prescriptions; or uses such communication or information, in whole or in part, to otherwise engage in the practice of pharmacy.

Notwithstanding sub-items (a) and (b) above, a pharmacy shall not be deemed an Internet pharmacy if it maintains an Internet web site for the following purposes only:

(i) Mere advertisements that do not attempt to facilitate, directly or through agreement with a third party, an actual transaction involving a prescription drug;

(ii) To allow a patient to communicate a request for a refill of a legitimate prescription originally filled by the pharmacy that maintains the Internet web site;

(iii) To allow a customer to research drug interactions and clinical pharmacology information; or

(iv) To allow a patient to send an electronic mail message to a pharmacist licensed in North Carolina.

21 NCAC 46.1601(d) provides:

(d) In addition to all of the other requirements for issuance and renewal of a pharmacy permit imposed by statute and rules of the Board, the Board shall not issue any original or annual renewal pharmacy permit to any Internet pharmacy until the Board is satisfied that:

(1) The Internet pharmacy is certified by the National Association of Boards of Pharmacy as a Verified Internet Pharmacy Practice Site (VIPPS);

(2) The Internet pharmacy has certified the percentage of its annual business conducted via the Internet on a form required by the Board, when it applies for permit or renewal; and

(3) The Internet pharmacy has provided the Board with the names, addresses, social security numbers, phone numbers, facsimile numbers, email addresses, and titles of all principal corporate officers of the Internet pharmacy; the names, addresses, social security numbers, phone numbers, facsimile numbers, email addresses, and titles of all principal officers of any company, partnership, association, or other business entity holding any ownership interest in the Internet pharmacy; the names, addresses, social security numbers, phone numbers, facsimile numbers, email addresses, and titles of any individual holding any ownership interest in the Internet pharmacy.

This Paragraph does not relieve an out-of-state pharmacy from compliance with all provisions of 21 NCAC 46 .1607 governing out-of-state pharmacies.

Pharmacists who would like more information about obtaining VIPPS® accreditation should visit the NABP Web site: *www.nabp.net.*

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.* FDA is accepting electronic comments on the guidance at *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.*

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.*

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) 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.

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® (cefpodoxime) 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*).
- **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*, 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*.

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.*

Item 2142 – Rule .2512 Governing Pharmacist Work Hours and Breaks Now Effective

21 NCAC 46.2512 became effective on April 1, 2007. The rule, entitled "Pharmacist Work Conditions," provides:

> A permit holder shall not require a pharmacist to work longer than 12 continuous hours per work day. A pharmacist working longer than six continuous hours per work day shall be allowed during that time period to take a 30 minute meal break and one additional 15 minute break.

At its April 17, 2007 meeting, the Board voted to allow a six-month "grace" period for implementation. Accordingly, Board staff will begin enforcing the rule on October 1, 2007. Board staff strongly encourages employers to use this time to make any necessary changes to work schedules.

Item 2143 – Proposed Amendment to Rule .2201 Governing Continuing Education Requirements

Effective January 1, 2008, the Board will have the authority to "require licensees to obtain up to 30 hours of continuing education every two years from Board-approved providers as a condition of license renewal, with a minimum of 10 hours required per year." NCGS §90-85.17.

Pursuant to this statutory authority, the Board has published proposed amendments to Rule .2201. If adopted, the new rule will read as follows:

(a) As a condition of license renewal, a pharmacist shall accumulate 15 hours of continuing education annually.

(b) Eight of these continuing education hours shall be obtained through contact programs. Contact programs are those in which there is an opportunity for live two-way communication between the presenter and attendee. An on-line continuing education course may satisfy this contact-hour requirement provided that the live two-way communication standard is met.

(c) A pharmacist who accumulates more than the required 15 hours of continuing education in a single year may carry forward up to five surplus hours to be applied to the following year's continuing education requirements.

(d) A pharmacist shall preserve all continuing education records for three years.

(e) Upon license renewal, the pharmacist shall report continuing education hours on a form approved and provided by the Board. The Board may require a pharmacist to submit records, reports of accredited hours and certificates of credit on a random basis pursuant to a continuing education audit.

(f) All continuing education shall be obtained through accredited continuing education courses. The Board shall approve continuing education courses as accredited if they provide education on matters that will maintain or increase the participant's professional competence and proficiency as a pharmacist.

(g) Continuing education shall not serve as a barrier to reciprocity; however all licensees by reciprocity must observe the continuing education standards specified in (a), (b), (c), (d), (e) and (f) of this Rule within the first renewal period after licensure in this state.

Item 2144 – Joint Statement from the Board and the North Carolina Division of Medical Assistance Concerning Proton Pump Inhibitors

The North Carolina General Assembly mandates pharmacists participating in the Medicaid program to substitute generic drugs for brand-name drugs unless the prescriber indicates "medically necessary" on the face of prescriptions for brand-name drugs. In support of this mandate, the North Carolina Board of Pharmacy and the North Carolina Division of Medical Assistance would like to notify pharmacists that prescriptions for brand-name Prilosec® 40 mg may be substituted with the equivalent dose of generic omeprazole 20 mg.

Pharmacists should consult with their Medicaid patients to inform them that they are receiving an appropriate generically equivalent medication and should also take care to consult with these patients on the appropriate use of the medication.

Item 2145 – Internet Solicitations

Board staff continues to receive reports of illegal Internet operations soliciting independent community pharmacies to act as fulfillment centers. Board staff is grateful for the information received from solicited pharmacies. A list of operations that have been ordered to cease and desist such solicitations in North Carolina is available at *www.ncbop.org/faqs/Pharmacist/faq_InternetCompanies.htm*

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