

Title 16. Board of Pharmacy
Proposed Language

To Amend § 1735 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735. Compounding in Licensed Pharmacies.

(a) "Compounding" means any of the following activities occurring in a licensed pharmacy, by or under the supervision of a licensed pharmacist, pursuant to a prescription:

- (1) Altering the dosage form or delivery system of a drug
- (2) Altering the strength of a drug
- (3) Combining components or active ingredients
- (4) Preparing a drug product from chemicals or bulk drug substances

(b) "Compounding" does not include reconstitution of a drug pursuant to a manufacturer's direction(s) for oral, rectal topical, or injectable administration, nor does it include tablet splitting or the addition of flavoring agent(s) to enhance palatability.

(c) "Compounding" does not include, except in small quantities under limited circumstances as justified by a specific, documented, medical need, preparation of a compounded drug product that is commercially available in the marketplace or that is essentially a copy of a drug product that is commercially available in the marketplace.

(d) The parameters and requirements stated by this Article 4.5 (Section 1735 et seq.) apply to all compounding practices. Additional parameters and requirements applicable solely to sterile ~~injectable~~ compounding are stated by Article 7 (Section 1751 et seq.).

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference:
Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1735.1 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.1. Compounding Definitions.

(a) "Anteroom" means an ISO Class 8 or better area where personnel hand hygiene and garbing procedures, staging of components, order entry, compounded sterile product labeling, and other high-particulate-generating activities are performed. It is a transition area that provides assurance that air flows from clean to dirty areas.

(b) "Batch" means more than one dose of a specific quantity of drug or other material that is intended to have uniform character and quality and is produced during the same continuous cycle of compounding.

(c) "Beyond use date" means the date after which a compounded drug product should not be used.

(d) "Buffer area" means an area where the ISO Class 5 hood is physically located.

(e) "Cleanroom" means a separate room meeting an ISO Class 7 or better air quality.

(f) "Controlled cold temperature" means 2° to 8° C (36° to 46° F)

(g) "Controlled freezer temperature" means -25° to -10° C (-13° to 14° F)

(h) "Controlled room temperature" means 20° to 25° C (68° to 77° F)

~~(a)~~ (i) "Equipment" means items that must be calibrated, maintained or periodically certified.

(j) "Gloved fingertip sampling" means the requirement that immediately after aseptic donning of sterile gloves compounding personnel will lightly press each fingertip and thumb onto appropriate growth media which will be incubated and then examined for growth of microorganisms.

~~(b)~~ (k) "Integrity" means retention of potency until the expiration date noted on the label.

(l) "Parenteral" means a sterile preparation of drugs for injection through one or more layers of skin.

(m) "Personal protective equipment" means clothing or devices that protect the employee from exposure to drug products and minimize the contamination of compounded sterile products and include shoe covers, head and facial hair covers, face masks, gowns, and gloves.

~~(e)~~ (n) "Potency" means active ingredient strength within +/- 10% of the labeled amount.

(o) "Process validation" means establishing by objective evidence that a process consistently produces a result or product meeting its predetermined specifications using microbiological simulation of an aseptic process with growth medium processed in a manner similar to the normal order of production and with the same container or closure.

~~(d)~~ (p) "Quality" means the absence of harmful levels of contaminants, including filth, putrid, or decomposed substances, and absence of active ingredients other than those noted on the label.

(q) "Segregated compounding area" means a designated space, either a demarcated area or room, that is restricted to preparing sterile-to-sterile compounded sterile products with a 12-hour or less beyond use date. Such area shall contain a device that provides unidirectional airflow of ISO Class 5 air quality for preparation of compounded sterile products and shall be void of activities and materials that are extraneous to sterile compounding.

(r) "Smoke test" means an analysis of the airflow in the ISO Class 5 hood using a smoke generating device.

~~(e)~~ (s) "Strength" means amount of active ingredient per unit of a compounded drug product.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference:
Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1735.2 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.2. Compounding Limitations and Requirements; Self-Assessment.

(a) Except as specified in (b) and (c), no drug product shall be compounded prior to receipt by a pharmacy of a valid prescription for an individual patient where the prescriber has approved use of a compounded drug product either orally or in writing. Where approval is given orally, that approval shall be noted on the prescription prior to compounding.

(b) A pharmacy may prepare and store a limited quantity of a compounded drug product in advance of receipt of a patient-specific prescription where and solely in such quantity as is necessary to ensure continuity of care for an identified population of patients of the pharmacy based on a documented history of prescriptions for that patient population.

(c) A “reasonable quantity” as used in Business and Professions Code section 4052(a)(1) means that amount of compounded drug product that:

(1) is sufficient for administration or application to patients in the prescriber’s office, or for distribution of not more than a 72-hour supply to the prescriber’s patients, as estimated by the prescriber; and

(2) is reasonable considering the intended use of the compounded medication and the nature of the prescriber’s practice; and

(3) for any individual prescriber and for all prescribers taken as a whole, is an amount which the pharmacy is capable of compounding in compliance with pharmaceutical standards for integrity, potency, quality and strength of the compounded drug product; and

(4) does not exceed an amount the pharmacy can reasonably and safely compound.

(d) A drug product shall not be compounded until the pharmacy has first prepared a written master formula record that includes at least the following elements:

(1) Active ingredients to be used.

(2) Equipment to be used.

(3) ~~Expiration dating requirements.~~ Beyond use dating requirements.

(4) Inactive ingredients to be used

(5) Process and/or procedure used to prepare the drug.

(6) Quality reviews required at each step in preparation of the drug.

(7) Post-compounding process or procedures required, if any.

(e) Where a pharmacy does not routinely compound a particular drug product, the master formula record for that product may be recorded on the prescription document itself.

(f) The pharmacist performing or supervising compounding is responsible for the integrity, potency, quality, and labeled strength of a compounded drug product until it is dispensed.

(g) All ~~chemicals, bulk drug substances,~~ drug products, and other components used for drug compounding shall be stored and used according to compendial and other applicable requirements to maintain their integrity, potency, quality, and labeled strength.

(h) Every compounded drug product shall be given an ~~expiration date~~ beyond use date representing the date beyond which, in the professional judgment of the pharmacist performing or supervising the compounding, it should not be used. This “beyond use date” of the compounded drug product shall not exceed 180 days from preparation or the shortest expiration date of any component in the compounded drug product, unless a longer date is supported by stability studies of finished drugs or compounded drug products using the same components and packaging. Shorter dating than set forth in this subsection may be used if it is deemed appropriate in the professional judgment of the responsible pharmacist.

(i) The pharmacist performing or supervising compounding is responsible for the proper preparation, labeling, storage, and delivery of the compounded drug product.

(j) Prior to allowing any drug product to be compounded in a pharmacy, the pharmacist-in-charge shall complete a self-assessment for compounding pharmacies developed by the board. (Incorporated by reference is “Community Pharmacy & Hospital Outpatient Pharmacy Compounding Self-Assessment” Form 17M-39 Rev. 02/12.) That form contains a first section applicable to all compounding, and a second section applicable to sterile ~~injectable~~ compounding. The first section must be completed by the pharmacist-in-charge before any compounding is performed in the pharmacy. The second section must be completed by the pharmacist-in-charge before any sterile ~~injectable~~ compounding is performed in the pharmacy. The applicable sections of the self-assessment shall subsequently be completed before July 1 of odd-numbered each year, within 30 days of the start of a new pharmacist-in-charge, and within 30 days of the issuance of a new pharmacy license. The primary purpose of the self-assessment is to promote compliance through self-examination and education.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code, Sections 1735, 1735.1, 1735.8, and 1751.1-1715.8 of Title 16 of the California Code of Regulations.

To Amend § 1735.3 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.3. ~~Records~~ Recordkeeping of Compounded Drug Products.

(a) For each compounded drug product, the pharmacy records shall include:

- (1) The master formula record.
- (2) The date the drug product was compounded.
- (3) The identity of the pharmacy personnel who compounded the drug product.
- (4) The identity of the pharmacist reviewing the final drug product.
- (5) The quantity of each component used in compounding the drug product.
- (6) The manufacturer, expiration date and lot number of each component. If the manufacturer name is demonstrably unavailable, the name of the supplier may be substituted. Exempt from the requirements in this paragraph are sterile products compounded on a one-time basis for administration within seventy-two (72) hours and stored in accordance with standards for “Redispensed CSPS” found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP36-NF31 through 1st Supplement) (~~35~~ 36th Revision, Effective ~~May~~ August 1, ~~2012-2013~~), hereby incorporated by reference, to an inpatient in a health care facility licensed under section 1250 of the Health and Safety Code.
- (7) A pharmacy assigned reference or lot number for the compounded drug product.
- (8) The ~~expiration~~ beyond use date of the final compounded drug product.
- (9) The quantity or amount of drug product compounded.

(b) Pharmacies shall maintain records of the proper acquisition, storage, and destruction of chemicals, bulk drug substances, drug products, and components used in compounding.

(c) Chemicals, bulk drug substances, and drug products, ~~and components~~ used to compound drug products shall be obtained from reliable FDA-registered suppliers. The pharmacy shall acquire and retain ~~any available~~ certificates of purity or analysis for chemicals, bulk drug substances, and drug products, ~~and components~~ used in compounding. ~~Certificates of purity or analysis are not required for drug products that are approved by the Food and Drug Administration.~~ Certificates of purity or analysis are to be matched to the product received.

(d) After receipt by the pharmacy, packages of ingredients that lack a supplier's expiration date cannot be used after one (1) year unless either appropriate inspection or testing indicates that the ingredient has retained its purity and quality for use in compounded drug products.

~~(d)~~ (e) Pharmacies shall maintain and retain all records required by this article in the pharmacy in a readily retrievable form for at least three years from the date the record was created.

Authority cited: Sections 4005, 4127, and 4169, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1735.5 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.5. Compounding Policies and Procedures.

(a) Any pharmacy engaged in compounding shall maintain a written policy and procedure manual for compounding that establishes procurement procedures, methodologies for the formulation and compounding of drugs, facilities and equipment cleaning, maintenance, operation, and other standard operating procedures related to compounding. The pharmacy shall follow its policies and procedures and failure to follow these policies and procedures shall be deemed unprofessional conduct.

(b) The policy and procedure manual shall be reviewed on an annual basis by the pharmacist-in-charge and shall be updated whenever changes in processes are implemented.

(c) The policy and procedure manual shall include the following:

(1) Procedures for notifying staff assigned to compounding duties of any changes in processes or to the policy and procedure manual.

(2) Documentation of a plan for recall of a dispensed compounded drug product where subsequent verification demonstrates the potential for adverse effects with continued use of a compounded drug product.

(3) The procedures for maintaining, storing, calibrating, cleaning, and disinfecting equipment used in compounding, and for training on these procedures as part of the staff training and competency evaluation process.

(4) Documentation of the methodology appropriate to compounded drug products used to ~~test~~ validate integrity, potency, quality, and labeled strength ~~of compounded drug products.~~

(5) Documentation of the methodology used to determine appropriate ~~expiration~~ beyond use dates for compounded drug products.

(6) Dates of annual reviews and signature or initials by the pharmacist-in-charge and dates of any revisions to the policies and procedures.

(7) The storage of compounded sterile drug products in the pharmacy and daily documentation of room, refrigerator, and freezer temperatures.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, ~~and 4127,~~ and 4301, Business and Professions Code.

To Amend § 1751 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

Article 7. Sterile ~~Injectable~~ Compounding

1751. Sterile ~~Injectable~~ Compounding; Compounding Area; Self-Assessment.

(a) Any pharmacy engaged in compounding sterile ~~injectable~~ drug products shall conform to the parameters and requirements stated by Article 4.5 (Section 1735 et seq.), applicable to all compounding, and shall also conform to the parameters and requirements stated by this Article 7 (Section 1751 et seq.), applicable solely to sterile ~~injectable~~ compounding.

(b) Any pharmacy compounding sterile ~~injectable~~ drug products shall have a designated compounding area for the preparation of sterile ~~injectable~~ drug products, ~~which shall meet the following standards:~~ The environments within the pharmacy shall meet the following standards:

(1) ~~Clean Room~~ Cleanroom and Work Station Requirements, shall be in accordance with Section 1250 of Title 24, Part 2, Chapter 12, of the California Code of Regulations.

(2) Walls, ceilings and floors shall be constructed in accordance with Section 1250 of Title 24, Part 2, Chapter 12, of the California Code of Regulations.

(3) ~~Be~~ The pharmacy shall be ventilated in a manner in accordance with Section 505.12 of Title 24, Part 4, Chapter 5 of the California Code of Regulations.

(4) ~~Be~~ The ISO environment shall be certified annually at least every six months by a qualified technician who is familiar with the methods and procedures for certifying laminar air flow hoods and ~~clean room~~ cleanroom requirements, in accordance with standards adopted by the United States General Services Administration and whenever the device or cleanroom is relocated, altered, or a service to the facility is performed that would impact the cleanroom or device. Certification records must be retained for at least 3 years.

(5) The pharmacy shall be arranged in accordance with Section 1250 of Title 24, Part 2, Chapter 12, of the California Code of Regulations. Items related to the compounding of sterile ~~injectable~~ drug products within the compounding area shall be stored in such a way as to maintain the integrity of an aseptic environment.

(6) A sink shall be included in accordance in Section 1250 of Title 24, Part 2, of the California Code of Regulations. Sinks and drains shall not be present in an ISO Class 7 or better cleanroom, in buffer area, nor adjacent to an ISO Class 5 hood in a segregated compounding area. A sink may be located in an anteroom.

(7) There shall be a refrigerator and/or freezer of sufficient capacity to meet the storage requirements for all material requiring refrigeration.

(c) Any pharmacy compounding a sterile ~~injectable~~ drug product from one or more non-sterile ingredients shall comply with Business and Professions Code section 4127.7.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, 4127 and 4127.7, Business and Professions Code; Sections 1735, 1735.1,-1735.8., and 1751.1-1751.8. of Title 16 of the California Code of Regulations; and Section 18944, Health and Safety Code.

To Amend § 1751.1 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.1. Sterile ~~Injectable~~ Compounding Recordkeeping Requirements.

(a) Pharmacies compounding sterile ~~injectable~~ drug products for future use pursuant to section 1735.2 shall, in addition to those records required by section 1735.3, make and keep records indicating the name, lot number, amount, and date on which the products were provided to a prescriber.

(b) In addition to the records required by section 1735.3 and subdivision (a), for sterile compounded drug products ~~compounded from one or more non-sterile ingredients~~, the following records must be made and kept by the pharmacy:

(1) The training and competency evaluation of employees in sterile product procedures.

(2) Results of gloved fingertip testing and aseptic technique media fill assessments.

(3) Results of viable volumetric air and surface sampling.

~~(2)~~ (4) Daily documentation of room, R refrigerator, and freezer temperatures appropriate for drug preparations consistent with the temperatures listed in section 1735.1 for:-

(A) Controlled room temperature.

(B) Controlled cold temperature.

(C) Controlled freezer temperature.

~~(3)~~ (5) Certification of the sterile compounding environment.

(6) Logs of room pressure differentials.

~~(4)~~ (7) Other facility quality control logs specific to the pharmacy's policies and procedures (e.g., cleaning logs for facilities and equipment).

~~(5)~~ (8) Inspections for expired or recalled pharmaceutical products or raw ingredients.

~~(6)~~ (9) Preparation records including the master work sheet, the preparation work sheet, and records of end-product evaluation results.

(c) Pharmacies shall maintain and retain all records required by this article in the pharmacy in a readily retrievable form for at least three years from the date the record was created.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference:

Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.2 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.2. Sterile ~~Injectable~~ Compounding Labeling Requirements.

In addition to the labeling information required under Business and Professions Code section 4076 and section 1735.4, a pharmacy which compounds sterile ~~injectable~~ drug products shall include the following information on the labels for those products:

- (a) Telephone number of the pharmacy, except for sterile ~~injectable~~ drug products dispensed for inpatients of a hospital pharmacy.
- (b) Name and concentrations of ingredients contained in the sterile ~~injectable~~ drug product.
- (c) Instructions for storage and handling.
- (d) All cytotoxic agents shall bear a special label which states "Chemotherapy - Dispose of Properly" or "Cytotoxic – Dispose of Properly."

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, 4076 and 4127, Business and Professions Code.

To Amend § 1751.3 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.3. Sterile ~~Injectable~~ Compounding Policies and Procedures.

- (a) Any pharmacy engaged in compounding sterile ~~injectable~~ drug products shall maintain a written policy and procedure manual for compounding that includes, in addition to the elements required by section 1735.5, written policies and procedures regarding the following:
 - (1) Compounding, filling, and labeling of sterile ~~injectable~~ compounds.
 - (2) Labeling of the sterile ~~injectable~~ drug product based on the intended route of administration and recommended rate of administration.
 - (3) Equipment and supplies.

- (4) Training of staff in the preparation of sterile ~~injectable~~ drug products.
- (5) Training of staff in the cleaning and maintenance of an ISO environment and segregated compounding areas.
- (6) A viable and nonviable sampling plan.
- (7) For barrier isolators, documentation of the manufacturer's recommended purge time.
- ~~(5)~~ (8) Procedures for handling cytotoxic agents.
- ~~(6)~~ (9) Quality assurance program.
- ~~(7)~~ (10) Record keeping requirements.
- (b) The ingredients and the compounding process for each preparation must be determined in writing before compounding begins and must be reviewed by a pharmacist.
- (c) Pharmacies compounding sterile ~~injectable~~ drug products shall have written policies and procedures for the disposal of infectious materials and/or materials containing cytotoxic residues. The written policies and procedures shall describe the pharmacy protocols for cleanups and spills in conformity with local health jurisdiction standards.
- (d) Pharmacies compounding sterile ~~injectable~~ drug products ~~from one or more non-sterile ingredients~~ must have written policies and procedures that comply with the following:
 - (1) All written policies and procedures shall be immediately available to all personnel involved in these activities and board inspectors.
 - (2) All personnel involved must read the policies and procedures before compounding sterile ~~injectable~~ drug products, and any additions, revisions, and deletions to the written policies and procedures must be communicated to all personnel involved in sterile compounding.
 - (3) Policies and procedures must address at least the following:
 - (A) Competency evaluation.
 - (B) Storage and handling of products and supplies.
 - (C) Storage and delivery of final products.
 - (D) Process validation.
 - (E) Personnel access and movement of materials into and near the controlled area.

(F) Use and maintenance of environmental control devices used to create the critical area for manipulation of sterile products (e.g., laminar-airflow workstations, biological safety cabinets, class 100 cleanrooms, and barrier isolator workstations).

(G) ~~Regular~~ Daily cleaning and disinfection schedule for the controlled area and any equipment in the controlled area ~~and the alternation of disinfectants~~ as specified in section 1751.4.

Pharmacies subject to an institutional infection control policy may follow that policy as it relates to cleaning schedules and the alternation of disinfectants in lieu of complying with this ~~subdivision~~ subparagraph.

(H) Disposal of packaging materials, used syringes, containers, and needles to enhance sanitation and avoid accumulation in the controlled area.

(I) For sterile batch compounding, written policies and procedures must be established for the use of master formulas and work sheets, ~~and for appropriate documentation,~~ and for sterility and bacterial endotoxin testing.

(J) ~~Sterilization.~~ For non-sterile to sterile compounding:

(i) Sterilization

~~(K) End-product evaluation and testing.~~

(ii) End-product evaluation and testing.

(K) Action levels for colony-forming units (CFUs) detected during viable surface testing and volumetric air sampling.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference:

Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.4 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.4. Facility and Equipment Standards for Sterile ~~Injectable~~ Compounding [from Non-Sterile Ingredients].

(a) No sterile ~~injectable~~ drug product shall be compounded if it is known, or reasonably should be known, that the compounding environment fails to meet criteria specified in the pharmacy's written policies and procedures for the safe compounding of sterile ~~injectable~~ drug products.

(b) During the preparation of sterile ~~injectable~~ drug products, access to the designated area or cleanroom must be limited to those individuals who are properly attired.

(c) All equipment used in the designated area or cleanroom must be made of a material that can be easily cleaned and disinfected.

(d) Cleaning and disinfecting surfaces in the ISO Class 5 hood shall occur frequently, including:

(i) at the beginning of shift;

(ii) before each batch;

(iii) every 30 minutes during continuous compounding of individual compounded sterile drug products;

(iv) after each spill;

(v) when surface contamination is known or suspected; and

(vi) when switching between cytotoxic and non-cytotoxic ingredients.

~~(d) (e) Exterior workbench surfaces and other hard surfaces in the designated area, such as walls, floors, ceilings, shelves, tables, and stools, must be disinfected weekly and after any unanticipated event that could increase the risk of contamination. Counters, cleanable work surfaces and floors shall be cleaned and disinfected daily. Walls, ceiling, storage shelving, tables and stools are to be cleaned and disinfected monthly. Cleaning shall occur after any unanticipated event that could increase the risk of contamination. Cleaning shall include the periodic use of a sporicidal agent.~~

~~(e) (f) Pharmacies preparing parenteral sterile cytotoxic agents shall do so in accordance with Section 505.12.1 of Title 24, Chapter 5, of the California Administrative Code, requiring a laminar air flow hood. The hood must be certified ~~annually~~ every six months by a qualified technician who is familiar with the methods and procedures for certifying laminar air flow hoods and cleanroom requirements, in accordance with ~~National Sanitation Foundation Standard 49 for Class II (Laminar Flow) Biohazard Cabinetry, as revised May, 1983~~ NSF International Standard/American National Standard for Biosafety Cabinetry - Biosafety~~

Cabinetry: Design, Construction, Performance, and Field Certification [NSF/ANSI 49-2012], as revised July 7, 2012 (available from the National Sanitation Foundation, 3475 Plymouth Road, P.O. Box 1468, Ann Arbor, Michigan 48106, phone number (313) 769-8010 Chair, Joint Committee on Biosafety Cabinetry c/o NSF International, P.O. Box 130140, 789 N. Dixboro Road, Ann Arbor, MI 48105, USA, phone number (734) 769-8010) or manufacturer's specifications. Certification records must be retained for at least 3 years. The hood shall be decontaminated when switching between cytotoxic and non-cytotoxic ingredients.

(g) Pharmacies preparing sterile cytotoxic agents shall use a biological safety cabinet or compounding aseptic containment isolator that provides an ISO Class 5 environment during dynamic compounding conditions which is maintained in accordance with the manufacturer's recommendations and which is certified every six months. If a compounding aseptic containment isolator meeting the above criteria is located outside of an ISO Class 7 area, the compounding area shall maintain a minimum negative pressure of 0.01-inch water column and have a minimum of 12 air changes per hour.

(h) Viable surface and volumetric air sampling by impaction shall occur at least every six months by a qualified technician who is familiar with the methods and procedures for surface testing and air sampling. Viable air sampling is to be performed under dynamic conditions that simulate actual production. Exceeded action levels shall prompt an immediate investigation of cleaning and compounding operations and facility management.

Note: Authority Cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052 and 4127, Business and Professions Code; and Section 18944, Health and Safety Code.

To Amend § 1751.5 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.5. Sterile ~~Injectable~~ Compounding Attire.

~~(a) When preparing cytotoxic agents, gowns and gloves shall be worn.~~

~~(b)~~ (a) When compounding sterile drug products from one or more non-sterile ingredients the following standards must be met:

(1) Cleanroom garb consisting of a ~~low non-shedding coverall gown~~, head cover, face mask, and shoe covers must be worn inside the designated area at all times.

(2) Cleanroom garb must be donned and removed in an anteroom or ~~outside the designated area~~ in a designated area immediately outside the segregated compounding area.

(3) Personnel shall don personal protective equipment in an order that proceeds from those activities considered the dirtiest to those considered the cleanest. The donning of shoe covers or dedicated shoes, head and facial hair covers and face masks shall be followed by the washing of hands and forearms up to the elbows for 30 seconds with soap and water and then the donning of a non-shedding gown. Cleansing with a persistently active alcohol-based product followed by the donning of sterile gloves must occur within the buffer area, not prior to entering. Gloves are to be routinely disinfected with sterile 70 percent isopropyl alcohol after contact with non-sterile objects.

~~(3)~~ (4) Compounding personnel shall not wear Hand, finger, and or wrist jewelry ~~must be eliminated~~. If jewelry cannot be removed then it must be thoroughly cleaned and covered with a sterile glove.

~~(4) Head and facial hair must be kept out of the critical area or be covered.~~

~~(5) Gloves made of low-shedding materials are required.~~ Sterile gloves that have been tested for compatibility with disinfection with isopropyl alcohol are required. Gloves shall also be routinely inspected for holes, punctures, or tears and replaced immediately if such are detected.

(6) Individuals experiencing rashes, sunburn, weeping sores, conjunctivitis, active respiratory infections, or those wearing cosmetics shall be excluded from working in ISO Class 5 and ISO Class 7 compounding areas until their conditions are remedied.

~~(c) The requirements of subdivision (b) do not apply if a barrier isolator is used to compound sterile injectable products from one or more non-sterile ingredients.~~

(b) When preparing cytotoxic agents, appropriate gowns and personal protective equipment shall be worn.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference:
Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.6 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.6 Training of Sterile ~~Injectable~~ Compounding Staff, Patient, and Caregiver.

(a) Consultation shall be available to the patient and/or primary caregiver concerning proper use, storage, handling, and disposal of sterile ~~injectable~~ drug products and related supplies furnished by the pharmacy.

(b) The pharmacist-in-charge shall be responsible to ensure all pharmacy personnel engaging in compounding sterile ~~injectable~~ drug products shall have training and demonstrated competence in the safe handling and compounding of sterile ~~injectable~~ drug products, including cytotoxic agents if the pharmacy compounds products with cytotoxic agents.

(c) Records of training and demonstrated competence shall be available for each individual and shall be retained for three years beyond the period of employment.

(d) The pharmacist-in-charge shall be responsible to ensure the continuing competence of pharmacy personnel engaged in compounding sterile ~~injectable~~ drug products.

(e) Pharmacies that compound sterile products ~~from one or more non-sterile ingredients~~ must comply with the following training requirements:

(1) The pharmacy must establish and follow a written program of training and performance evaluation designed to ensure that each person working in the designated area has the knowledge and skills necessary to perform their assigned tasks properly. This program of training and performance evaluation must address at least the following:

(A) Aseptic technique.

(B) Pharmaceutical calculations and terminology.

(C) Sterile product compounding documentation.

(D) Quality assurance procedures.

(E) Aseptic preparation procedures using media fill tests which are as complicated as the most complex manipulations performed by staff and which contain the same amount of volume transferred during the compounding process.

(F) Proper gowning and gloving technique.

(G) General conduct in the controlled area.

(H) Cleaning, sanitizing, and maintaining equipment used in the controlled area.

(I) Sterilization techniques for compounding sterile drug products from one or more non-sterile ingredients.

(J) Container, equipment, and closure system selection.

(2) Each person ~~assigned to the controlled area~~ who handles compounded sterile drug products must successfully complete practical skills training in aseptic technique and aseptic area practices. Evaluation must include written testing and a written protocol of periodic routine performance checks involving adherence to aseptic area policies and procedures. Each person's proficiency and continuing training needs must be reassessed every 12 months. Results of these assessments must be documented and retained in the pharmacy for three years.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference:

Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.7 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.7. Sterile ~~Injectable~~ Compounding Quality Assurance and Process Validation.

(a) Any pharmacy engaged in compounding sterile ~~injectable~~ drug products shall maintain, as part of its written policies and procedures, a written quality assurance plan including, in addition to the elements required by section 1735.8, a documented, ongoing quality assurance program that monitors personnel performance, equipment, and facilities. The end product shall be examined on a periodic sampling basis as determined by the pharmacist-in-charge to assure

that it meets required specifications. The Quality Assurance Program shall include at least the following:

(1) Cleaning and sanitization of the ~~parenteral medication~~ sterile preparation area.

~~(2) The storage of compounded sterile injectable products in the pharmacy and periodic documentation of refrigerator temperature.~~

~~(3)~~ (2) Actions to be taken in the event of a drug recall.

~~(4)~~ (3) Written justification of the chosen ~~expiration~~ beyond use dates for compounded sterile ~~injectable~~ drug products.

(b) Each individual involved in the preparation of sterile ~~injectable~~ drug products must first successfully complete a validation process on technique before being allowed to prepare sterile ~~injectable~~ drug products. The validation process shall be carried out in the same manner as normal production, except that an appropriate microbiological growth medium is used in place of the actual product used during sterile preparation. ~~The validation process shall be representative of all types of manipulations, products and batch sizes the individual is expected to prepare.~~ The validation process shall be as complicated as the most complex manipulations performed by staff and which contain the same amount of volume transferred during the compounding process. The same personnel, procedures, equipment, and materials must be involved. Completed medium samples must be incubated in a manner consistent with the manufacturer's recommendations and demonstrated to promote growth. If microbial growth is detected, then the sterile preparation process must be evaluated, corrective action taken, and the validation process repeated. Personnel competency must be revalidated at least every twelve months for sterile to sterile compounding and at least every six months for individuals compounding sterile products from non-sterile ingredients, whenever the quality assurance program yields an unacceptable result, when the compounding process changes, equipment used in the compounding of sterile ~~injectable~~ drug products is repaired or replaced, the facility is modified in a manner that affects airflow or traffic patterns, or whenever improper aseptic techniques are observed. Revalidation must be documented.

(c) All compounding personnel must successfully complete an initial competency evaluation. In addition, immediately following the hand hygiene and garbing procedure, all compounding

personnel must successfully complete a gloved fingertip sampling procedure (zero colony forming units) at least three times before initially being allowed to compound sterile drug products.

(d) Re-evaluation of garbing and gloving competency shall occur at least annually for personnel compounding products made from sterile ingredients and at least every six months for personnel compounding products from non-sterile ingredients.

~~(e)~~ (e) Batch-produced sterile injectable drug products compounded from one or more non-sterile ingredients shall be subject to documented end product testing for sterility in accordance with methodologies and processes found in Chapter 71 of the United States Pharmacopeia – National Formulary (USP36-NF31 through 1st Supplement) (36th Revision, Effective August 1, 2013), and pyrogens in accordance with the methods of Chapters 85 and 151 of the United States Pharmacopeia – National Formulary (USP36-NF31 through 1st Supplement) (36th Revision, Effective August 1, 2013), hereby incorporated by reference, and shall be quarantined until the end product testing confirms sterility and acceptable levels of pyrogens before dispensing. Products submitted for sterility testing are to include preparations from the beginning, middle, and end of each batch. This requirement of end product testing confirming sterility and acceptable levels of pyrogens prior to dispensing shall apply regardless of any sterility or pyrogen testing that may have been conducted on any ingredient or combination of ingredients that were previously non-sterile.

~~(d)~~ (f) Batch-produced sterile to sterile transfers shall be subject to periodic testing through process validation for sterility as determined by the pharmacist-in-charge and described in the written policies and procedures.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference:
Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.8 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.8. Beyond Use Dating for Sterile Compounded Drug Products.

In addition to the requirements and limitations of section 1735.2, subdivision (h), every sterile compounded drug product shall be given and labeled with a beyond use date as follows.

(a) Where the sterile compounded drug product was compounded solely with aseptic manipulations entirely within an ISO Class 5 hood located in an ISO Class 7 buffer area with an anteroom, using only sterile ingredients, products, components, and devices, in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP36-NF31 through 1st Supplement) (36th Revision, Effective August 1, 2013), hereby incorporated by reference, the beyond use date shall specify that storage and exposure periods for the sterile compounded drug product cannot exceed the following:

- (1) 48 hours at controlled room temperature
- (2) 14 days at controlled cold temperature
- (3) 45 days at controlled freezer temperature

(b) Where the sterile compounded drug product was compounded solely with aseptic manipulations entirely within an ISO Class 5 hood located in an ISO Class 7 buffer area with an anteroom, using multiple individual or small doses of sterile products combined or pooled to prepare a compounded sterile product that will be administered either to multiple patients or to one patient on multiple occasions, in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP36-NF31 through 1st Supplement) (36th Revision, Effective August 1, 2013), hereby incorporated by reference, the beyond use date shall specify that storage and exposure periods for the sterile compounded drug product cannot exceed the following:

- (1) 30 hours at controlled room temperature
- (2) 7 days at controlled cold temperature

(3) 45 days at controlled freezer temperature

(c) Where the sterile compounded drug product was compounded solely with aseptic manipulations entirely within an ISO Class 5 hood located in an ISO Class 7 buffer area with an anteroom, using nonsterile ingredients, including manufactured products not intended for sterile routes of administration, or nonsterile devices, before terminal sterilization, or where the sterile compounded drug product lacks effective antimicrobial preservatives, in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP36-NF31 through 1st Supplement) (36th Revision, Effective August 1, 2013), hereby incorporated by reference, the beyond use date shall specify that storage and exposure periods for the sterile compounded drug product cannot exceed the following:

(1) 24 hours at controlled room temperature

(2) 3 days at controlled cold temperature

(3) 45 days at controlled freezer temperature

(d) Where the sterile compounded drug product was compounded solely with aseptic manipulations entirely within an ISO Class 5 hood in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP36-NF31 through 1st Supplement) (36th Revision, Effective August 1, 2013) hereby incorporated by reference, the beyond use date shall be 12 hours.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Add § 1751.9 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.9 Single-Dose and Multi-Dose Containers; Limitations on Use

(a) Any single-dose container of sterile drug product or compounded sterile drug product other than an ampule, such as a bag, bottle, syringe or vial, shall be used in its entirety or its remaining contents discarded within the following time limit, depending on the environment:

(1) When opened or needle-punctured in an environment with air quality worse than ISO Class 5, within one (1) hour;

(2) When opened or needle-punctured in an environment with ISO Class 5 or better air quality, within six (6) hours.

(b) Single-dose ampules are for immediate use only, and once opened or needle-punctured shall not be stored for any time period.

(c) Unless otherwise specified by the manufacturer, a multi-dose container shall be used in its entirety or its remaining contents discarded within twenty eight (28) days from initial opening or puncture.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.10 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.8, 1751.10. Sterile Compounding Reference Materials.

In any pharmacy engaged in compounding sterile drug products, there shall be current and appropriate reference materials regarding the compounding of sterile drug products located in or immediately available to the pharmacy.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.11 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

~~1751.10.~~ 1751.11. Furnishing to Parenteral Patient at Home.

Subject to all provisions of this article, a pharmacist may carry and furnish to a patient at home dangerous drugs, other than controlled substances, and devices for parenteral therapy when the dangerous drug or device is one currently prescribed for the patient.

Authority cited: Section 4005, Business and Professions Code. Reference: Section 4005, Business and Professions Code.

To Amend § 1751.12 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

~~1751.11.~~ 1751.12. Furnishing to Home Health Agencies and Licensed Hospices.

Subject to the following conditions, a licensed pharmacy may furnish to a home health agency licensed under provisions of Chapter 8 (commencing with section 1725 of Division 2 of the Health and Safety Code) or to a hospice licensed under provisions of Chapter 8.5 (commencing with section 1745 of Division 2 of the Health and Safety Code) dangerous drugs for parenteral therapy other than controlled substances, in a portable container for furnishing to patients at home for emergency treatment or adjustment of parenteral drug therapy by the home health agency or licensed hospice.

(a) The pharmacy, having ownership and responsibility for the portable containers, shall ensure that each portable container is:

- (1) furnished by a registered pharmacist;
- (2) sealed in such a manner that a tamper-proof seal must be broken to gain access to the drugs;
- (3) under the effective control of a registered nurse, pharmacist or delivery person at all times when not in the pharmacy;
- (4) labeled on the outside of the container with a list of the contents;
- (5) maintained at an appropriate temperature according to United States Pharmacopeia Standards (1995, 23rd Revision), and protected at all times from extreme temperatures that could damage the contents.

(b) The portable container may contain up to:

(1) 1000mL of 0.9% sodium chloride intravenous infusion in containers of a size determined by the pharmacy;

(2) 1000mL of 5% dextrose in water injection in containers of a size determined by the pharmacy;

(3) two vials of urokinase 5000 units;

(4) Each of the following items shall be in sealed, unused containers; the furnishing pharmacy may select any or all of these dangerous drugs in up to five dosage units for inclusion in the sealed, portable container:

(A) heparin sodium lock flush 100 units/mL;

(B) heparin sodium lock flush 10 units/mL;

(C) epinephrine HCl solution 1:1000;

(D) epinephrine HCl solution 1:10,000;

(E) diphenhydramine HCl 50mg/mL;

(F) methylprednisolone 125mg/2mL;

(G) normal saline, preserved, up to 30 mL vials;

(H) naloxone 1mg/mL 2 mL;

(I) droperidol 5mg/2mL;

(J) prochlorperazine 10mg/2mL;

(K) promethazine 25mg/mL;

(L) dextrose 25gms/50mL;

(M) glucagon 1mg/mL;

(N) insulin (human) 100 units/mL;

(O) bumetamide 0.5mg/2mL;

(P) furosemide 10mg/mL;

(Q) EMLA Cream 5 gm tube;

(R) Lidocaine 1 percent 30mL vials.

(5) The pharmacy shall ensure that the specific dangerous drugs and quantities to be included in the portable container are listed in the home health agency's or licensed hospice's policy and procedures.

(c) The pharmacy shall not supply a portable container to a home health agency or licensed hospice which does not:

(1) implement and maintain policies and procedures for:

- (A) the storage, temperature stability and transportation of the portable container;
 - (B) the furnishing of dangerous drugs from the portable container upon the written or oral authorization of a prescriber; and
 - (C) a specific treatment protocol for the administration of each medication contained in the portable container.
- (2) have the policies, procedures and protocols reviewed and revised (as needed) annually by a group of professional personnel including a physician and surgeon, a pharmacist and a registered nurse.
- (d) A copy of these policies, procedures and protocols shall be maintained by the furnishing pharmacy from each home health agency or licensed hospice for which the pharmacy furnishes portable containers.
 - (e) In cases where a drug has been administered to a patient pursuant to the oral order of a licensed prescriber, the pharmacy shall ensure that the oral order is immediately written down by the registered nurse or pharmacist and communicated by copy or fax within 24 hours to the furnishing pharmacy, with a copy of the prescriber-signed document forwarded to the dispensing pharmacy within 20 days.
 - (f) The pharmacy shall ensure that within seven days (168 hours) after the seal has been broken on the portable container, the home health agency's director of nursing service or a registered nurse employed by the home health agency or licensed hospice returns the container to the furnishing pharmacy. The furnishing pharmacy shall then perform an inventory of the drugs used from the container, and if the container will be reused, must restock and reseal the container before it is again furnished to the home health agency or licensed hospice.
 - (g) The furnishing pharmacy shall have written policies and procedures for the contents, packaging, inventory monitoring, labeling and storage instructions of the portable container.
 - (h) The furnishing pharmacy shall ensure that the home health agency or licensed hospice returns the portable containers to the furnishing pharmacy at least every 60 days for verification of product quality, quantity, integrity and expiration dates, or within seven days (168 hours) after the seal has been broken.
 - (i) The furnishing pharmacy shall maintain a current inventory and record of all items placed into and furnished from the portable container.

Note: Authority cited: Sections 4005 and and 4057, Business and Professions Code. Reference: Sections 4040, 4057, 4081 and 4332, Business and Professions Code.

To Amend § 1751.13 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

~~1751.12~~ 1751.13. Obligations of a Pharmacy Furnishing Portable Containers.

(a) A licensed pharmacy shall not issue portable containers to any home health agency or licensed hospice unless the home health agency or licensed hospice complies with provisions of section 1751.11.

(b) A licensed pharmacy shall cease to furnish portable containers to a home health agency or licensed hospice if the home health agency or licensed hospice does not comply with provisions of section 1751.11.

Note: Authority cited: Sections 4005 and 4057, Business and Professions Code. Reference: Sections 4040, 4057, 4081 and 4332, Business and Professions Code.