BEFORE THE
BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

COVINA PHARMACY INCORPORATED doing business as COVINA PHARMACY, VIRGINIA CHANG, PRESIDENT AND SOLE SHAREHOLDER

Pharmacy Permit Number PHY 31167,

and

VIRGINIA CHANG

Pharmacist License Number RPH 31744.

Respondents.

Agency No. 7148

OAH No. 2021090705

DECISION AND ORDER

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Pharmacy, Department of Consumer Affairs, as its Decision in this matter, except that, pursuant to the provisions of Government Code section 11517, subdivision (c)(2)(C), the following technical change is made to:

- Page 11, Analysis of Evidence, paragraph 18, second paragraph, line 10 should read as “Covina Pharmacy” instead of “Covid Pharmacy”.

The technical change made above does not affect the factual or legal basis of the Proposed Decision, which shall become effective at 5:00 p.m. on August 4, 2022.

It is so ORDERED on July 5, 2022.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By 

Seung W. Oh, Pharm.D.
Board President

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PROPOSED DECISION

Administrative Law Judge Deena R. Ghaly, Office of Administrative Hearings (OAH), State of California, heard this matter on April 25 and 26, 2022, by videoconference.

Deputy Attorney General Stephen D. Svetich represented Complainant Anne Sodergren, Executive Officer of the Board of Pharmacy (Board), Department of Consumer Affairs. Attorney Ronald H. Chew represented Respondents Covina Pharmacy (Covina Pharmacy) and Virginia Chang (Chang) (collectively, Respondents).

Testimony and documentary evidence were received and argument was heard. The record closed, and the matter was submitted for decision on April 26, 2022.

SUMMARY

Complainant seeks to discipline Respondents for failing to accurately record dispensing pharmacist information, dispensing controlled substance prescriptions written on insufficient prescription documents, and filling prescriptions for controlled substances despite "red flags" of illegitimacy and potential drug misuse. Clear and convincing evidence established grounds for disciplinary action. Applying the Board's disciplinary guidelines to the relevant facts, the appropriate level of discipline is permit and license revocation.

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FACTUAL FINDINGS

Background and Jurisdictional Matters

1. On April 1, 1985, the Board issued Pharmacy Permit Number PHY 31167 to Covina Pharmacy. The pharmacy permit was in full force and effect at all times relevant to the charges brought herein. License certification records presented at the hearing reflected that Pharmacy Permit Number PHY 31167 expired on April 1, 2022.

2. On January 11, 1978, the Board issued Pharmacist License Number RPH 31744 to Chang. The pharmacist license was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2022, unless it is revoked or renewed. Chang is Covina Pharmacy's president and sole shareholder, as well as its pharmacist-in-charge.

3. In December 1998, in the case In the Matter of the Accusation Against Covina Pharmacy, Inc., doing business as Covina Pharmacy, and Virginia Chang, Case Number 1882, the Board disciplined Respondents for excessively refilling prescriptions for commonly abused pain medications and suspended Respondents' permit and license for one year, with the suspension stayed pending three years' probation.

4. On July 29, 2021, Complaint, acting solely in her official capacity, signed the Accusation commencing the instant matter. Respondents timely filed a notice of defense challenging the charges in the Accusation and this hearing followed.

Board's Investigation and Charges

5. The Controlled Substance Utilization Review and Evaluation System (CURES) is a database which stores information regarding the prescribing and dispensing of controlled substances. A review of CURES reports conducted during investigations of doctors' prescription practices showed that, from November 2017 through November 2020, Covina Pharmacy dispensed controlled substance prescriptions to patients exhibiting irregularities and "red flags" consistent with

possible illegitimate prescribing and indiscriminate pharmacy dispensing. Thereafter, the Board initiated an investigation into Respondents' dispensing activities.

Hearing

COMPLAINANT'S CASE

Irina Top, Pharm.D.

6. Board Inspector Irina Top, Pharm.D. (Insp. Top), investigated Respondents. Insp. Top received her undergraduate degree from the University of California (UC), Los Angeles and her Doctor of Pharmacy degree from the UC, San Francisco. She has been a licensed pharmacist in California since 2009, working in a retail pharmacy, an acute care facility, and a hospital. In 2014, Insp. Top joined the Board in her current capacity as an investigator. There, she received training in investigation.

7. Insp. Top's investigation included reviewing Covina Pharmacy's electronic dispensing records, prescription documents and other documentation relating to patient care, pharmacy records, and CURES reports.

8. Insp. Top found rates and types of prescriptions written by Drs. J.D. and M.R. (initials are used to protect the doctors' privacy) and filled at Covina Pharmacy to be notable for signs of pharmacy law violations.

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Regarding Dr. J.D., between September 24, 2019 and November 30, 2020, he wrote 741 prescriptions filled at Covina Pharmacy which included 381 for controlled substances. Between November 1, 2017 and December 1, 2020, 39 percent of the prescriptions for Oxycodone 30 mg, the strongest available dose in pill form, were written under the authority of Dr. J.D. Ninety-three percent of prescriptions written by

Dr. J.D. and filled at Covina Pharmacy were paid for with cash. The majority of Dr. J.D.'s patients for whom he wrote prescriptions filled at Covina Pharmacy, 60 of 80, obtained Oxycodone 30 mg. At least 20 of these patients were "opioid naive," meaning their records indicated no recent opioid use. Most of the patients for whom Dr. J.D. wrote prescriptions for Oxycodone 30 mg received the same instruction, three pills a day. All eight of Dr. J.D.'s office locations are at least 25 miles away from Covina Pharmacy, the furthest is 39 miles away. Except for 13 of the 80 patients, all lived 21 miles or more away, the furthest reporting a home address 123 miles from Covina Pharmacy. Almost all of Dr. J.D.'s patients had the diagnosis code for back pain documented on their prescriptions. Groups of Dr. J.D.'s patients presented with prescriptions for identical or similar medications, quantities, and directions for use on the same day, and the prescriptions bore the same lot number and bore sequential or close batch numbers indicating they had been written in close succession.

Regarding Dr. M.R., Insp. Top determined that, based on her inspection of the original documents, he wrote five prescriptions, three for Oxycodone 30 mg and two for Hydrocodone/Acetaminophen 10/325 mg, on prescription forms which did not have a watermark printed on the backside consisting of the words, "California Security Prescription." Additionally, the prescription documents signed by Dr. M.R. did not bear a lot number and, based on Insp. Top's investigation, listed a medical facility address which does not exist. Despite these insufficiencies, in March 2020, Covina Pharmacy filled the prescriptions.

9. After interviewing Covina Pharmacy staff pharmacist T.L., Insp. Top concluded certain prescriptions recorded as dispensed by Chang were actually dispensed by T.L. but recorded in the pharmacy's computer system under Chang's username.

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10. Insp. Top explained that, when pharmacists note red flags in prescriptions, the correct protocol is to resolve them before filling the prescription. Appropriate methods of resolving red flags are to ask clients about their diagnoses, check their CURES reports, contact the prescribing doctor, and even review the prescribing patterns of doctors who have multiple patients retrieving their drugs at one pharmacy. If the red flags cannot be resolved, the pharmacist should refuse to fill the prescription.

Other Evidence

11. Complainant presented evidence that the Board has published articles and other notices for years about pharmacists' role in the proper prescribing and dispensing of controlled substances, referred to as a 'corresponding responsibility,' including recognizing and resolving the red flags indicating potentially illegitimate practices. (See Exh. 35.) Many of the red flags listed there are consistent with the ones noted by Insp. Top during her review of Covina Pharmacy's records.

12. Complainant presented cost certifications that the Board incurred $15,778.25 in costs to investigate the case, and that the Department of Justice has billed the Board another $12,583.75 in costs to prepare the case for hearing. The total of these costs is $28,058. These costs are reasonable for the complexity and scope of the investigation and enforcement action.

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Respondent's Evidence

13. At hearing, Chang admitted her practices with her staff pharmacist regarding accurately recording which of them dispensed prescriptions had been problematic, but she has taken steps to make sure this was corrected.

14. Regarding the issue of Dr. M.R.'s prescriptions being written without security features, Chang agreed they did not bear the appropriate watermark and lot number; however, through counsel, she argued as a partial defense that they were submitted during the "grandfathering" period before the law requiring the watermark completely took effect. In support of her argument, Respondents submitted a copy of AB-149, an assembly bill which amended Health and Safety Code section 11162.1. Counsel highlighted the following text in the assembly bill:

> This bill would delay the requirement for those prescription forms to include a uniquely serialized number until a date determined by the Department of Justice that is no later than January 1, 2020. The bill would require, among other things, the serialized number to be utilized as a barcode that may be scanned by dispensers. The bill would additionally make any prescription written on a prescription form that was otherwise valid prior to January 1, 2019, but that does not include a uniquely serialized number, or any prescription written on a form approved by the Department of Justice as of January 1, 2019, a valid prescription that may be filled, compounded, or dispensed until January 1, 2021. The bill would authorize the Department of Justice to extend this time period for a period no longer than an additional 6 months, if there is an inadequate availability of compliant prescription forms.

(Exh. A, p. 1.)

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Respondents also submitted a bulletin from the Board dated December 18, 2019 stating the following:

> AB 149 delayed the requirement for controlled substance prescription forms to have unique serialized numbers until January 1, 2020. The law also imposed new form requirements for controlled substance prescription forms.
>
> However, a transition period was included within AB 149 to support an orderly shift by prescribers to the new forms. The following controlled substance prescription forms will be valid for filling, compounding, or dispensing until January 1, 2021:
>
> Any prescription written on a prescription form that does not have a unique serialized number but was otherwise valid before January 1, 2019.
>
> Any prescription written on a form approved by the Department of Justice as of January 1, 2019. This will include the fifteen (15) digit serialized number format approved by the Department of Justice.

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> Any prescription written on a form that complies with the new requirement imposed by AB 149, including a compliant serial number and a bar code.

(Exh. B.)

15. Regarding whether Respondents met their corresponding responsibility, Chang maintained she does what she can to verify the appropriateness and legitimacy of the prescriptions submitted at Covina Pharmacy while also meeting the need to be helpful and accommodating to her clientele and the doctors she hopes will refer their patients to Covina Pharmacy. According to Chang, personalized relationships with doctors and outstanding customer service is a necessary part of maintaining her business.

16. Chang further testified that she personally knows Dr. J.D. and has known him since opening Covina Pharmacy when, as part of her efforts to promote her business, Chang introduced herself to him. According to Chang, Dr. J.D., as a pain specialist, is himself careful to screen patients for drug-seeking behavior, including requiring them to submit to urinalysis to check for improper or excessive drug use. Her own efforts include calling the prescribers from time to time, including approximately half of Dr. J.D.'s patients, inquiring about their diagnoses, and reviewing CURES reports. Chang also stated Dr. J.D. recommends to his patients that they fill their prescriptions at Covina Pharmacy.

Asked whether she finds it suspect that her customers would come from miles to fill their prescriptions, she stated she believes her outstanding service, including preparing and packaging drugs in advance, is a draw for many of them. She further stated she is aware of at least one client who "told all his friends" about Covina Pharmacy. Regarding why Dr. J.D.'s prescriptions sometimes come to her pharmacy in sequential batches, Chang stated caregivers with multiple patients who are all treated by Dr. J.D., take them all at once to see him and bring the prescriptions all together to be filled. She also stated that, in the case of Oxycodone, her primary wholesale provider shipped quantities of this medication on set days of the month and, because this medication is difficult to get and often rationed by the wholesaler, Chang sets

aside some for her "regulars," which, upon reflection, occurred to Chang as another reason why some clients traveled such far distances to fill their prescriptions at Covina Pharmacy.

17. Respondents introduced the testimony of Dr. John Cho, a board-certified anesthesiologist and pain management specialist. Dr. Cho completed his residency in anesthesiology at Loma Linda University Medical Center and a fellowship in pain management at Loma Linda University Health Care Center for Pain Management and Research. Dr. Cho stated that it is impossible to tell whether a prescription is legitimate or illegitimate by just looking at it and that pharmacists are not in a position to second guess doctors or to substitute their judgment for that of the prescribing practitioner. Moreover, standards for both doctors and pharmacists are continually changing, with professionals incurring criticism and discipline for both under and over medicating patients while treating their pain. Both doctors and pharmacists are therefore in a difficult position when assisting people requiring this type of medical intervention. And, in fact, in Dr. Cho's experience, there are individuals in such dire pain that only very strong doses of medication will offer relief.

Dr. Cho further stated there are reasonable explanations for some of the anomalies Insp. Top relied upon in determining Respondents improperly filled prescriptions. Travel from far distances can be because patients/clients are seeking continuity of care, knowing that if they change pharmacies, their prescriptions for controlled substances will be questioned and maybe refused. Patients also fear their insurance rates will increase or their insurance companies will drop their coverage if they are known to use opioids. According to Dr. Cho, these are the complications patients face regardless of legitimate need for the drugs, a situation which imposes extraordinary hardship on people already facing dire circumstances as a result of their medical conditions.

Analysis of Evidence

18. Insp. Top's testimony and reports establish that many prescriptions dispensed from Covina Pharmacy contained red flags that should have raised suspicions about their legitimacy and the possibility of drug abuse.

Dr. Cho presented persuasive and compelling evidence about the complexities involved in prescribing and dispensing controlled substances; his testimony skillfully described the dilemmas faced by professionals, including pharmacists, who must make difficult decisions about their patients/clients' need for controlled substances, particularly opioids. The explanations he provided, however, do not account for all the particular circumstances in the instant matter. Here, not only are Insp. Top's findings demonstrative of prescriptions bearing sufficient red flags to warrant at least further inquiry, Chang's own testimony about trying to accommodate referring doctors, including Dr. J.D., clients telling friends about the availability of controlled substances at Covid Pharmacy, and the financial challenges of running a community pharmacy, indicates that her very business model ran in conflict with her professional duty to exercise corresponding responsibility. In short, based on her candid assertions, Chang was not in a position to both keep her business alive and meet the requirements to review and, if necessary, refuse to fill suspect prescriptions.

Regarding inaccurate dispensing records, Insp. Top's determinations that a staff pharmacist had sometimes input prescription records under Chang's username were corroborated by Chang's admission. As for whether Dr. M.R.'s controlled substance prescription forms lacked the required lot number and watermark, Insp. Top's and Chang's testimony established this fact. Chang's proffered defense – that the controlled substance prescriptions bear the correct watermark was not completely in effect at the time of the Board's investigation – is not correct. A review of past versions

of the applicable law, Health and Safety Code section 11162.1 reflect that the watermark requirement was part of the statute since at least 2003.

LEGAL CONCLUSIONS

General Provisions

1. Business and Professions Code (further undesignated code sections are to the Business and Professions Code) section 4011 provides the Board shall administer and enforce both the Pharmacy Law (§ 4000 *et seq.*) and the Uniform Substances Act (Health & Saf. Code § 11000 *et seq.*).

2. Section 4300.1 states:

The expiration, cancellation, forfeiture, or suspension of a board-issued license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

3. Section 4302 states, "The board may deny, suspend, or revoke any license where conditions exist in relation to any person holding 10 percent or more of the ownership interest or where conditions exist in relation to any officer, director, or other person with management or control of the license that would constitute grounds for disciplinary action against a licensee."

Section 4156 states, "A pharmacy corporation shall not do, or fail to do, any act where doing or failing to do the act would constitute unprofessional conduct under

any statute or regulation." Section 4113 provides that the pharmacist-in-charge is responsible for a pharmacy's compliance with all applicable laws and regulations pertaining to pharmacy practice.

Burden and Standard of Proof

4. A pharmacist license is a professional license. (§ 4050, subd. (a); *Murphy v. E.R. Squibb & Sons, Inc.* (1985) 40 Cal.3d 672, 678-679.) To impose discipline on a professional license, cause for discipline must be proved by clear and convincing evidence to a reasonable certainty. (*Sternberg v. California State Bd. of Pharmacy* (2015) 239 Cal.App.4th 1159, 1171; *Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence "requires a finding of high probability," and has been described as "requiring that the evidence be "so clear as to leave no substantial doubt" [Citation.]. *(In re Angelia P.* (1981) 28 Cal.3d 908, 919.)

5. Covina Pharmacy's pharmacy permit is a nonprofessional license because it does not have extensive educational, training, or testing requirements similar to a professional license. (See *Mann v. Dept. of Motor Vehicles* (1999) 76 Cal.App.4th 312, 319; *San Benito Foods v. Veneman* (1996) 50 Cal.App.4th 1889, 1894.) To impose discipline on Covina Pharmacy's nonprofessional pharmacy permit, Complainant must prove cause for discipline by a preponderance of the evidence, which is a lower standard of proof than clear and convincing evidence. (Evid. Code, §115.) A preponderance of the evidence means "'evidence that has more convincing force than that opposed to it.' [Citation.]" (*People ex rel. Brown v. Tri-Union Seafoods, LLC* (2009) 171 Cal.App.4th 1549, 1567.)

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Causes for Discipline

FIRST CAUSE OF DISCIPLINE – FAILURE TO MAINTAIN DISPENSING PHARMACIST INFORMATION

6. Pursuant to Section 4301, the Board may discipline a licensee for unprofessional conduct including "(o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of this chapter or of the applicable federal and state laws and regulations governing pharmacy, including regulations established by the board or by any other state or federal regulatory agency." California Code of Regulations, title 16 (Regulation), section 1717 requires a licensed pharmacy and its pharmacist-in-charge to maintain on file, in readily retrievable form, electronic records of the dispensing pharmacist for each prescription. It is axiomatic that a record reflect the correct dispensing pharmacist to comply with Regulation section 1717.

Clear and convincing evidence established Respondents failed to fulfill their obligation under Regulation section 1717 when a staff pharmacist working under Chang's authority dispensed drugs under Chang's username as set out in Factual Findings 9 and 13.

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SECOND CAUSE OF DISCIPLINE

7. Health and Safety Code sections 11162.1 provides that controlled substance prescription forms shall be printed with a watermark consisting of the words ("California Security Prescription") (subd. (a)(2)) and a lot number printed on the form (subd. (b).). Health and Safety Code section 11164 requires all Schedule II, III, IV, or V

drugs, which include Oxycodone and Hydrocodone, to be written on controlled substance prescription forms.

Clear and convincing evidence established Respondents violated Health and Safety Code section 11162.1, subdivisions (a)(2) and (b) and section 11164, subdivision (a) by filling prescriptions for Oxycodone and Hydrocodone written by Dr. M.R. on controlled substance prescription forms which did not bear the correct watermark and which did not have a lot number printed on it as set out in Factual Findings 8 – 10, 15, and 18.

THIRD CAUSE OF DISCIPLINE – CORRESPONDING RESPONSIBILITY

8. The third cause for discipline alleges Chang is subject to disciplinary action under section 4301, subdivisions (j) and (o), because she "failed to fulfill her corresponding responsibility by repeatedly failing to resolve irregularities and red flags of illegitimacy in prescriptions and dispensing controlled substances pursuant to the prescriptions." (Exhibit 1, p. 18.)

Clear and convincing evidence established Respondents failed to meet their corresponding responsibility pursuant to the applicable statutory requirements. Insp. Top's investigation established red flags existed in many prescriptions filled at Covina Pharmacy and Chang's testimony established that they were not sufficiently observed and appropriately resolved at least in part because Chang concerned herself with pleasing her patients and referring doctors in a manner inconsistent with her professional duties, as set out in Factual Findings 3 and 18.

Disposition

9. Section 4300 states:

(a) Every license issued may be suspended or revoked.

(b) The Board shall discipline the holder of any license [it issued], whose default has been entered or whose case has been heard by the board and found guilt, by any of the following methods:

(1) Suspending judgment.

(2) Placing him or her upon probation.

(3) Suspending his or her right to practice for a period not exceeding one year.

(4) Revoking his or her license.

(5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper.

10. Section 4307 provides in pertinent part, in the case of licensee owning or managing a corporation which itself is licensed by the Board and the corporation's license is disciplined for conduct which the licensee manager or owner "had knowledge of or knowingly participated in," the licensee owner or manager:

shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee as follows:

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(1) Where a probationary license is issued or where an existing license is placed on probation, this prohibition shall remain in effect for a period not to exceed five years.

(2) Where the license is denied or revoked, the prohibition shall continue until the license is issued or reinstated.

(b) "Manager, administrator, owner, member, officer, director, associate, partner, or any other person with management or control of a license" as used in this section and Section 4308, may refer to a pharmacist or to any other person who serves in such capacity in or for a licensee.

11. The Board's disciplinary guidelines, incorporated by reference in its regulations (Reg., § 1760 et seq.) list 17 factors to be considered in determining whether the minimum, maximum, or intermediate penalty should be imposed in a given case. "No single one or combination of the factors is required to justify the minimum [or] maximum penalty in a given case, as opposed to an intermediate one." (Disciplinary Guidelines, p. 3.) The factors and their application to this case are addressed below:

(1) and (2) Actual or potential harm to the public or to any consumer. Respondents' violations potentially harmed both the public and the consumers who frequented Covina Pharmacy. Dispensing controlled substances without proper documentation and record-keeping, proper prescriptions, and without adequate review of prescriptions raising red

flags leave patients without the proper safeguards to assure dangerous drugs are not misused or abused.

(3) and (4) Prior disciplinary record, including level of compliance with any resulting order; prior warnings such as citations, letters of admonishment or correction notices – Respondent Chang incurred a disciplinary finding against her license in 1998. Although remote in time, the charges involved are similar to the ones arising in the instant case, an aggravating factor.

(5) Number and variety of current violations. Respondents incurred three types of violations and filled hundreds of prescriptions in violation of one or more of the applicable statutes or regulations.

(6) Nature and severity of the acts under consideration. Respondents' failure to maintain accurate records of the dispensing pharmacist is a Category I violation. Under the Guidelines, a Category I violation is the least serious. Respondents' failure to abide by controlled substance form requirements is a Category II violation, meaning it is at an intermediate level of seriousness. Respondents' failure to meet their corresponding responsibility obligation is a Category III violation, more serious than level II but less than the most serious, Category IV.

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(7) Aggravating evidence. Respondents' prior disciplinary record is an aggravating factor.

(8) Mitigating evidence. Respondent Chang has been a licensed pharmacist in California for over 45 years and has owned and run Covina Pharmacy for 38 years.

(9) Rehabilitation evidence. Respondent Chang presented very limited evidence of rehabilitation. For the most part, she denied both wrongdoing and responsibility, and did not provide evidence of improved practices except to the extent that she has instructed her subordinates to document prescriptions filled under their own credentials.

(10), (11), and (12) Compliance with terms of any criminal sentence or order; overall criminal record; evidence of dismissal or expungement under Penal Code section 1203.4. These factors are inapplicable.

(13) Time passed since the acts at issue. Respondents committed the acts at issue between three and five years ago, i.e., relatively recent.

(14) Whether the conduct was intentional or negligent, demonstrated incompetence, or, if the respondents are being held to account for conduct committed by another, whether they had knowledge of, or knowingly participated. During her testimony, Chang stated, while she made some efforts to address red flags she noted, she refrained from

pursuing the matter to any great extent because she feared repercussions to her business. Her level of conduct is best characterized as negligent

(15) Financial benefit to the respondent from the misconduct. As noted above, Chang considered her conduct to be a necessary part of staying business; however, any financial gain was indirect as opposed to, for instance, receiving kickbacks or additional fees for filling illegitimate prescriptions

(16) Other licenses held by respondents and license history of those licenses. This factor is inapplicable.

(17) Uniform Standards Regarding Substance-Abusing Healing Arts Licensees. This factor is inapplicable.

12. The Guidelines also utilize the four categories of violations to determine the appropriate penalty. When there are "multiple violations, the appropriate penalty shall increase accordingly." (Disciplinary Guidelines. at p. 5.) Additionally, "if an individual has committed violations in more than one category, the minimum and maximum penalties shall be those recommended in the highest category." (*Ibid.*) Here, the minimum penalty is stayed revocation with a term of probation and a 90 day suspension. The maximum penalty is revocation.

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13. Considering the factors and the entire record in the instant matter, the appropriate level of discipline is revocation. Chang is a long-time licensee. In short, she should know better, have much greater self-awareness, and have a heightened sense

of professional responsibility even when there could be business costs. Instead, Chang remains mired in short-term goals and gains. It is unlikely that, even with remedial education, Chang will become more cognizant and accepting of those responsibilities or that she will develop the sort of professional judgment consistent with the public safety. Chang shall also be prohibited from owning or managing any Board-licensed premises unless and until her pharmacist license is reinstated.

Costs

14. Complainant has requested an award of the Board's costs of investigation and enforcement of the case. Unless otherwise provided by law, "in any order issued in resolution of a disciplinary proceeding before any board within the [Department of Consumer Affairs] upon request of the entity bringing the proceeding, the administrative law judge may direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case." (§ 125.3, subd. (a).)

In evaluating a request for costs, the administrative law judge must consider whether complainant's investigation was "disproportionately large" compared to the violation, and whether the licensee: (1) committed some misconduct but "used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed;" (2) had a "'subjective good faith belief in the merits of his or her position;'" (3) raised a "'colorable challenge'" to the proposed discipline; and (4) "will be financially able to make later payments." (*Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45 [quoting *California Teachers Assn. v. State of California* (1999) 20 Cal.4th 327, 342, 345].)

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Here, Respondents did not manage to obtain dismissal or reduction in the severity of the discipline imposed or raise any colorable challenge. There is no reason to doubt Chang's subjective belief in the merits of her case; however, that factor cannot justify a reduction of the costs. It is reasonable to assume that revocation of the permits and licenses may change Respondents' financial ability to pay the Board's costs. As such, the costs awarded will only become due if and when Chang's pharmacy license is reinstated and shall be paid pursuant to a payment plan as approved by the Board.

ORDER

1. Pharmacy Permit Number PHY 31167, issued to Covina Pharmacy Incorporated, doing business as Covina Pharmacy, Virginia Chang, President and sole shareholder, is revoked.
2. Pharmacist License Number RPH 31744, issued to Virginia Chang is revoked.
3. Upon reinstatement of Virginia Chang's pharmacy license by the Board of Pharmacy, she will pay $28,058 pursuant to a payment plan the Board approves.
4. Covina Pharmacy Incorporated is prohibited from serving as a manager, administrator, owner, member officer, director, associate, or partner of a licensee until and unless its pharmacy permit is reinstated.

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5. Virginia Chang is prohibited from serving as a manager, administrator, owner, member officer, director, associate, or partner of a licensee until and unless her pharmacist license is reinstated.

DATE: 05/26/2022

Deena R. Ghaly
Deena R. Ghaly (May 26, 2022 11:53 PDT)

DEENA R. GHALY
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against**:** **COVINA PHARMACY INCORPORATED DBA COVINA PHARMACY, VIRGINIA CHANG, PRESIDENT AND SOLE SHAREHOLDER** **174 West Badillo** **Covina, CA 91723** **Pharmacy Permit No. PHY 31167,** **and** **VIRGINIA CHANG** **174 W. Badillo Street** **Covina, CA 91723** **Pharmacist License No. RPH 31744** Respondents.	Case No. 7148 **ACCUSATION**

PARTIES

1. Anne Sodergren ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Pharmacy, Department of Consumer Affairs.

2. On or about April 1, 1985, the Board of Pharmacy ("Board") issued Pharmacy Permit Number PHY 31167 to Covina Pharmacy Incorporated, doing business as Covina Pharmacy

(Respondent Covina). Respondent Virginia Chang ("Respondent Chang") is the president and sole shareholder of Respondent Covina. The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on April 1, 2022, unless renewed.

3. On or about January 11, 1978, the Board issued Pharmacist License Number RPH 31744 to Respondent Chang. The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2022, unless renewed.

JURISDICTION

4. This Accusation is brought before the Board, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

5. Section 4300 of the Code states:

> (a) Every license issued may be suspended or revoked.
>
> (b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:
>
> (1) Suspending judgment.
>
> (2) Placing him or her upon probation.
>
> (3) Suspending his or her right to practice for a period not exceeding one year.
>
> (4) Revoking his or her license.
>
> (5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper.
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> …
>
> (e) The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code, and the board shall have all the powers granted therein. The action shall be final, except that the propriety of the action is subject to review by the superior court pursuant to Section 1094.5 of the Code of Civil Procedure.

6. Section 4300.1 of the Code states:

> The expiration, cancellation, forfeiture, or suspension of a board-issued license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

7. Section 4302 of the Code states, "The board may deny, suspend, or revoke any license where conditions exist in relation to any person holding 10 percent or more of the ownership interest or where conditions exist in relation to any officer, director, or other person with management or control of the license that would constitute grounds for disciplinary action against a licensee."

8. Section 4307 of the Code states:

> (a) Any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under suspension, or who has been a manager, administrator, owner, member, officer, director, associate, partner, or any other person with management or control of any partnership, corporation, trust, firm, or association whose application for a license has been denied or revoked, is under suspension or has been placed on probation, and while acting as the manager, administrator, owner, member, officer, director, associate, partner, or any other person with management or control had knowledge of or knowingly participated in any conduct for which the license was denied, revoked, suspended, or placed on probation, shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee as follows:
>
> (1) Where a probationary license is issued or where an existing license is placed on probation, this prohibition shall remain in effect for a period not to exceed five years.
>
> (2) Where the license is denied or revoked, the prohibition shall continue until the license is issued or reinstated.
>
> (b) "Manager, administrator, owner, member, officer, director, associate, partner, or any other person with management or control of a license" as used in this section and Section 4308 , may refer to a pharmacist or to any other person who serves in such capacity in or for a licensee.
>
> (c) The provisions of subdivision (a) may be alleged in any pleading filed pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code. However, no order may be issued in that case except as to a person who is named in the caption, as to whom the pleading alleges the applicability of this section, and where the person has been given notice of the proceeding as required by Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code. The authority to proceed as provided by this subdivision shall be in addition to the board's authority to proceed under Section 4339 or any other provision of law.

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STATUTORY PROVISIONS

9. Section 4022 of the Code states

> Dangerous drug or dangerous device means any drug or device unsafe for self-use in humans or animals, and includes the following:
>
> (a) Any drug that bears the legend: Caution: federal law prohibits dispensing without prescription, Rx only, or words of similar import.
>
> (b) Any device that bears the statement: Caution: federal law restricts this device to sale by or on the order of a _____, Rx only, or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.
>
> (c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

10. Section 4113 of the Code states:

> (a) Every pharmacy shall designate a pharmacist-in-charge and, within 30 days thereof, shall notify the board in writing of the identity and license number of that pharmacist and the date he or she was designated.
>
> (b) The proposed pharmacist-in-charge shall be subject to approval by the board. The board shall not issue or renew a pharmacy license without identification of an approved pharmacist-in-charge for the pharmacy.
>
> (c) The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy…

11. Section 4156 of the Code states, "A pharmacy corporation shall not do, or fail to do, any act where doing or failing to do the act would constitute unprofessional conduct under any statute or regulation. In the conduct of its practice, a pharmacy corporation shall observe and be bound by the laws and regulations that apply to a person licensed under this chapter."

12. Section 4301 of the Code states:

> The board shall take action against any holder of a license who is guilty of unprofessional conduct or whose license has been issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:
>
> …
>
> (d) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153 of the Health and Safety Code.
>
> …
>
> (j) The violation of any of the statutes of this state, of any other state, or of the United States regulating controlled substances and dangerous drugs.

…

(o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of this chapter or of the applicable federal and state laws and regulations governing pharmacy, including regulations established by the board or by any other state or federal regulatory agency…

13. Section 4306.5 of the Code states:

Unprofessional conduct for a pharmacist may include any of the following:

(a) Acts or omissions that involve, in whole or in part, the inappropriate exercise of his or her education, training, or experience as a pharmacist, whether or not the act or omission arises in the course of the practice of pharmacy or the ownership, management, administration, or operation of a pharmacy or other entity licensed by the board.

(b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services.

(c) Acts or omissions that involve, in whole or in part, the failure to consult appropriate patient, prescription, and other records pertaining to the performance of any pharmacy function.

(d) Acts or omissions that involve, in whole or in part, the failure to fully maintain and retain appropriate patient-specific information pertaining to the performance of any pharmacy function.

HEALTH AND SAFETY CODE STATUTES

14. Section 11153 of the Healthy and Safety Code provides in part:

(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use....

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15. Health and Safety Code Section 11162.1 states, in part:

"(a) The prescription forms for controlled substances shall be printed with the following features:

. . .

(2) A watermark shall be printed on the backside of the prescription blank; the watermark shall consist of the words "California Security Prescription."

. . .

(b) Each batch of controlled substance prescription forms shall have the lot number printed on the form and each form within that batch shall be numbered sequentially beginning with the numeral one."

16. Section 11164 of the Health and Safety Code states, in pertinent part:

Except as provided in Section 11167, no person shall prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for a controlled substance, unless it complies with the requirements of this section.

(a) Each prescription for a controlled substance classified in Schedule II, III, IV, or V, except as authorized by subdivision (b), shall be made on a controlled substance prescription form as specified in Section 11162.1. . . .

STATE REGULATORY AUTHORITY

17. California Code of Regulations, title 16, section 1712, states:

(a) Any requirement in this division for a pharmacist to initial or sign a prescription record or prescription label can be satisfied by recording the identity of the reviewing pharmacist in a computer system by a secure means. The computer used to record the reviewing pharmacist's identity shall not permit such a record to be altered after it is made.

(b) The record of the reviewing pharmacist's identity made in a computer system pursuant to subdivision (a) of this section shall be immediately retrievable in the pharmacy.

18. California Code of Regulations, title 16, section 1717, states:

. . . .

(b) In addition to the requirements of Section 4040, Business and Professions Code, the following information shall be maintained for each prescription on file and shall be readily retrievable:

(1) The date dispensed, and the name or initials of the dispensing pharmacist. All prescriptions filled or refilled by an intern pharmacist must also be initialed by the supervising pharmacist before they are dispensed. . . .

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19. California Code of Regulations, title 16, section 1761, states:

> (a) No pharmacist shall compound or dispense any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any such prescription, the pharmacist shall contact the prescriber to obtain the information needed to validate the prescription.
>
> (b) Even after conferring with the prescriber, a pharmacist shall not compound or dispense a controlled substance prescription where the pharmacist knows or has objective reason to know that said prescription was not issued for a legitimate medical purpose.

FEDERAL REGULATORY AUTHORITY

20. Code of Federal Regulations, title 21, section 1306.04, states:

> (a) A prescription for a controlled substance to be effective must be issued
>
> course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances. . . .

COST RECOVERY

21. Section 125.3 of the Code states, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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DEFINITIONS

22. The following drugs and controlled substances are relevant to the charges alleged herein:

TABLE NUMBER 1
Drug and Controlled Substance Definitions

BRAND NAME	GENERIC NAME	DANGEROUS DRUG PER B&P CODE § 4022?	CONTROLLED SUBSTANCE PER HEALTH AND SAFETY CODE	INDICATIONS FOR USE
Roxicodone	Oxycodone	Yes	Yes - Schedule II per Health and Safety Code § 11055, subd. (b)(1)(M)	Pain
Norco	Hydrocodone/ Acetaminophen	Yes	Yes- Schedule II per Health and Safety Code § 11055, subd. (b)(1)(I) (ii); Schedule II per CFR, Title 21, § 1308.12(b)(1)(vi)	Pain
Xanax	Alprazolam	Yes	Yes - Schedule IV per Health and Safety Code § 11057, subd. (d)(1)	Anxiety

FACTUAL ALLEGATIONS

23. Opioids are drugs most often utilized to treat pain. Tolerance and dependence on opioids will develop with continuous use, requiring increasing doses and leading to withdrawal syndrome upon abrupt discontinuation. Because of opioids' reputation for addiction and fatal overdose, they are highly controlled substances. The terms "opioid tolerant"[1] and "opioid naïve"[2] are clinically accepted and widely used. Opioid tolerance renders patients less susceptible to the effects of opioids, including both pain relief and adverse effects. If a patient is opioid naïve, treatment should be initiated slowly with dose escalation and their response more closely

[1] A patient is opioid tolerant if the patient takes, for one week or longer, at least: 60 mg oral morphine per day; 30 mg oral oxycodone per day; 8 mg oral hydromorphone per day; 60 mg oral hydrocodone per day; 25 mcg per hour of transdermal fentanyl; or an equianalgesic dose of any other opioid. An "equianalgesic dose" is the dose of two opioids required to produce the same

[2] A patient is considered opioid naïve if the patient does not meet the definition opioid tolerant because the patient has not taken opioid doses identified in footnote 1, above, for at least one week. For purposes of this investigation and accusation, the Board's investigator considered a patient opioid naïve if the patient had not filled an opioid for over two months.

monitored. The opioid naïve patient is at greater risk for complications, especially sedation and respiratory depression.

24. The Controlled Substance Utilization Review and Evaluation System ("CURES") requires mandatory monthly pharmacy reporting of dispensed schedule II-IV medications and controlled substances. The data is collected statewide. The Prescription Drug Monitoring Program ("PDMP") is a component of CURES accessible to pharmacists and prescribers. All practitioners licensed to prescribe or dispense scheduled medications were required by law to sign up for PDMP by July 1, 2016. The data in the PDMP is used by prescribers and pharmacists to aid in determining whether patients are utilizing their controlled substances safely and appropriately, ensuring they are not obtaining medical care from multiple prescribers, frequenting multiple pharmacies, obtaining early refills of controlled substances, travelling far distances to prescribers or pharmacies, consistently paying cash for their controlled substance prescriptions, or attempting to fill high dose opioids or benzodiazepines when they are naïve to either medication.

25. If a physician writes a controlled substance prescription that is not for a legitimate medical purpose, the pharmacist shares a corresponding responsibility or liability with that physician if he or she fills that prescription while knowing or having objective reason to know that the prescription was not issued for a legitimate medical purpose. The Board posted an informational bulletin titled, "Corresponding Responsibility, It's the Law" on its website. The bulletin outlines several "red flags" that should alert a pharmacy and pharmacist to a potential problem with prescriptions:

i. Irregularities on the face of the prescription;

ii. Nervous patient demeanor; age or presentation of a patient (e.g., a youthful patient seeking chronic pain medications);

iii. Multiple patients at the same address;

iv. Cash payments;

v. Requests for early refills of prescriptions; prescriptions written for an unusually large quantity of drugs;

vi. Prescriptions written for potentially duplicative drugs;

vii. The same combinations of drugs prescribed for multiple patients;

viii. Initial prescriptions written for strong opiates;

ix. Long distances traveled from the patient's home to the prescriber's office or to the pharmacy;

x. Irregularities in the prescriber's qualifications in relation to the medication(s) prescribed;

xi. Prescriptions that are written outside of the prescriber's medical specialty;

xii. Prescriptions for medications with no logical connection to diagnosis or treatment;

xiii. Patients coming to the pharmacy in groups, especially if their home addresses are outside the pharmacy's local trade area, each with the same prescriptions issued by the same prescriber;

xiv. The same diagnosis codes for many patients; and

xv. Excessively celebratory patient demeanor.

Prescriptions Written by Dr. J. D.

26. A review of Respondent Covina's CURES records showed that from November 6, 2017, to November 6, 2020, Respondent Covina dispensed controlled substance prescriptions to patients exhibiting irregularities and widely recognized red flags consistent with possible illegitimate prescribing and indiscriminate pharmacy dispensing. The Board initiated an investigation into Respondent Covina's dispensing activities and received from Respondent Covina electronic dispensing records from November 1, 2017, to December 1, 2020.

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27. A Board investigator reviewed Respondent Covina's dispensing records from November 1, 2017, to December 1, 2020, for prescriptions written by Dr. J. D. He wrote the following 741 prescriptions that were dispensed by Respondent Covina from September 24, 2019, to November 30, 2020:

TABLE NUMBER 2
Dr. J. D. Prescriptions Filled by Respondent Covina from September 24, 2019-November 30, 2020

Drug	Schedule	Number of Prescriptions
Oxycodone 30 MG Tablet	2	296
Docusate 100 MG Capsule	N/A	254
Horizant 600 MG Tablet	N/A	49
Gabapetin 300 MG Capsule	N/A	30
Oxy/APAP 10/325 MG Tablet	2	26
H/APAP 10/325 Tablet	2	31
Oxycodone 15 MG Tablet	2	8
Ibuprofen 800 MG Tablet	N/A	8
Oxymorphone ER 15 MG Tablet	2	6
Cyclobenzaprine 10 MG Tablet	N/A	5
Oxymorphone ER 40 MG Tablet	2	5
Amoxicillin 500 MG Capsule	N/A	5
Oxycodone 20 MG Tablet	2	4
Ibuprofen 600 MG Tablet	N/A	4
Losartan 50 MG Tablet	N/A	2
Butal/ASA/Caffeine Capsule	3	2
Lidocaine 5% Ointment	N/A	1
Oxycodone 10 MG Tablet	2	1
Metronidazole 500 MG Tablet	N/A	1
Docusate 100 MG Tablet	N/A	1
Oxymorphone ER 40 MG Tablet	2	1
Oxy/APAP 7.5/325 MG Tablet	2	1
TOTAL		**741**

28. Analysis of Dr. J. D.'s prescriptions filled by Respondent Covina raised the following red flags or factors of irregularity:

i. 381 of 741 (51%) of the prescriptions written by Dr. J. D. and dispensed by Respondent Covina were for a controlled substance. This percentage of controlled substance dispensing was higher than Respondent's overall pattern of dispensing during the same period (13% of the overall prescriptions dispensed by Respondent Covina were for controlled substances).

ii. From November 1, 2017, to December 1, 2020, Respondent Covina dispensed 766 prescriptions for oxycodone 30 mg, a highly abused controlled substance. 39% of these prescriptions were written under the prescription authority of Dr. J. D.

iii. 689 of the 741 (93%) of the prescriptions written by Dr. J. D. and dispensed by Respondent Covina were paid for with cash. This is significantly higher than the pharmacy's overall cash payments for controlled substances (37%).

iv. The most prescribed drug by Dr. J. D. was oxycodone 30 mg, the highest strength for that particular drug. 60 of 80 patients (75%) who received prescriptions from Dr. J. D. that were dispensed by Respondent Covina were prescribed oxycodone 30 mg without regard to interpatient variability. At least 20 of Dr. J. D.'s patients prescribed oxycodone 30 mg were opioid naïve.

v. Almost all of the patients prescribed oxycodone 30 mg by Dr. J. D. were given the same instructions (take one tablet, three times per day as needed).

vi. The addresses listed for Dr. J. D.'s medical practices on the prescription documents indicated he saw patients at the following eight medical offices, all of which are a far distance from Respondent Covina's pharmacy:

a. Randolph Street (approximately 25 miles away from the pharmacy);

b. Westwood Blvd. (approximately 36 miles away from the pharmacy);

c. Vernon Avenue (approximately 27 miles away from the pharmacy);

d. Los Feliz Blvd. (approximately 27 miles away from the pharmacy);

e. Western Avenue (approximately 28 miles away from the pharmacy);

f. E. Hardy Street (approximately 36 miles away from the pharmacy);

g. E. 17th Street (approximately 31 miles away from the pharmacy); and

h. Artesia Blvd. (approximately 39 miles away from the pharmacy).

vii. Many of Dr. J. D.'s patients resided a far distance from the pharmacy, as exhibited in the following table:

TABLE NUMBER 3
DISTANCE FROM PATIENT'S HOME TO PHARMACY[3]

Number	Patient	Distance from Patient's Home to Pharmacy (in Miles)
1	D. N.	30
2	R. S.	28
3	A. D.	30
4	P. G.	24
5	G. Y.	21
6	L. R.	49
7	J. V.	25
8	M. C.	31
9	V. L.	24
10	A. L.	22
11	D. M.	21
12	V. R.	84
13	K. N.	31
14	K. S.	33
15	B. W.	58
16	F. A.	33
17	T. B.	33
18	E. W.	29
19	K. M.	58
20	M. K.	31
21	F. J.	29
22	R. D.	67
23	J. T.	63
24	R. W.	30
25	D. S.	30
26	A. C.	34

[3] This table does not include the 13 patients who live less than 20 miles from the pharmacy.

27	D. R.	35
28	M. L.	31
29	J. M.	36
30	J. T.	27
31	S. M.	20
32	V. D.	32
33	D. S.	89
34	S. W.	29
35	D. H.	60
36	C. C.	29
37	A. P.	27
38	Le. N.	36
39	La. N.	32
40	I. T.	32
41	R. W.	60
42	M. F.	47
43	J. T.	91
44	S. H.	58
45	V. B.	89
46	D. W.	39
47	K. H.	30
48	E. U.	91
49	A. A.	43
50	S. S.	41
51	E. W.	79
52	K. M.	31
53	A. W.	59
54	I. M.	31
55	M. A.	123
56	A. J.	69
57	K. K.	60
58	G. F.	30
59	N. S.	28
60	A. M.	109
61	E. E.	37
62	J. W.	27
63	D. E.	37
64	H. N.	24
65	G. G.	33
66	O. S.	59
67	K. T.	28

viii. Almost all of Dr. J. D.'s patients had the same diagnosis code[4] documented on the prescriptions.

ix. Groups of Dr. J. D.'s patients presented with prescriptions for identical or similar medications, quantities, and directions for use on the same day. In many cases, the prescriptions had the same lot number and were close or sequential in batch number, indicating they may have been written by Dr. J. D. in close succession.

x. Analysis of CURES reports for Dr. J. D. printed by Respondent Covina (and stapled to many of the prescriptions produced by Respondent Covina) revealed that Dr. J. D. prescribed high dose oxycodone to many opioid naïve patients. Almost all of the opioid naïve patients were prescribed 90 mg[5] of oxycodone per day.

29. Respondent Chang dispensed 296 of the 381 controlled prescriptions (26,665 tablets) written by Dr. J. D.

Irregular Prescriptions

30. Respondent Covina dispensed controlled substances to patients who presented to the pharmacy with prescriptions displaying multiple factors of irregularity and red flags. Respondent Chang dispensed all 11 irregular controlled substance prescriptions outlined below. Respondent Covina and Respondent Chang filled the following prescriptions that were not issued in the usual course of professional treatment:

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[4] Almost all the patients had the diagnosis code 54.17, which is for radiculopathy of the lumbosacral region of the back. This describes a range of symptoms produced by the pinching of a nerve root in the spinal column.

[5] 90 mg of oxycodone is 135 morphine milligram equivalents ("MME") per day. CDC Guidelines state that clinicians should use caution when prescribing opioids at any dosage. They should carefully reassess evidence of individual benefits and risks when considering increasing dosage to above 50 MME per day, should avoid increasing dosage to more than 90 MME per day or carefully justify a decision to titrate dosage to more than 90 MME per day.

TABLE NUMBER 4
Irregular Prescriptions

Patient	Rx. No.	Date Dispensed	Drug	Opioid/ Benzo-diazapine Naïve when Rx Issued and Filled?	Paid for in Cash?	Patient's Distance from Pharmacy (in Miles)	Prescriber's Distance from Pharmacy (in Miles)
S. W.	257139	12/18/2019	Alprazolam 2 mg tablets	Yes	Yes	30	38
S. W.	248545	7/30/2020	Oxycodone 30 mg tablets	Yes	Yes	30	38
E. W.	238826	5/1/2019	Oxycodone 30 mg tablets	Yes	Yes	27	25
D. T.	243048	8/7/2019	Oxycodone 30 mg tablets	Yes	Yes	2.3	27
P. R.	220649[6]	5/29/2018	Oxycodone 30 mg tablets	Yes	Yes	28.5	26
H. M.	241914	7/12/2019	Oxycodone 30 mg tablets	Yes	Yes	8.5	17
H. M.	242025	7/15/2019	Alprazolam 2 mg tablets	Yes	Yes	8.5	17
L. I.	223419[7]	7/10/2018	Alprazolam 2 mg tablets	Yes	Yes	0.1	24
J. C.	228216[8]	10/2/2018	Oxycodone 30 mg tablets	Yes	Yes	1.9	32
J. B.	243499	8/16/2019	Oxycodone 30 mg tablets	Yes	Yes	6.5	27
S. R.	252343[9]	3/23/2020	Oxycodone 30 mg tablets	Yes	Yes	37	30

[6] Carisoprodol, another commonly abused controlled substance, was also dispensed to Patient P. R. on the same day.

[7] Patient L. I. was benzodiazepine naïve, and the dosage and instructions in this prescription was up to eight times the recommended starting dose. When Respondent Covina dispensed this prescription, Patient L. I. was concomitantly taking oxycodone 30 mg, the highest strength of that drug.

[8] Carisoprodol, another commonly abused controlled substance, was also dispensed to Patient J. C. on the same day.

[9] The prescription indicates Patient S. R. received urgent care treatment at Magnolia Urgent Care in Oxnard, CA, on March 9, 2020. It is a factor of irregularity that the patient sought urgent care treatment at a facility approximately 65 miles away from her residence. It is also irregular that the patient waited two weeks to fill the prescription purportedly for urgent care treatment.

Non-Compliant Prescriptions

31. Respondent Covina dispensed the following five prescriptions under the prescribing authority of Dr. M. R., that were written on a prescription document that failed to comply with security features required by Health and Safety Code section 11162.1:

TABLE NUMBER 5
Non-Compliant Prescriptions

Prescription Number	Date Prescription Dispensed	Patient	Drug	Patient's Distance from Pharmacy (Miles)
252343	3/23/2020	S. R.	Oxycodone 30 mg tablets	37
251835	3/10/2020	O. G.	Hydrocodone/ACET 10/325 mg	37
251837	3/10/2020	D. S.	Hydrocodone/ACET 10/325 mg	10.6
252346	3/23/2020	I. M.	Oxycodone 30 mg tablets	24
252348	3/23/2020	E. E.	Oxycodone 30 mg tablets	37

32. The prescription documents for the prescriptions outlined in Table Number 5, above, did not have a watermark printed on the backside of the prescription document consisting of the words, "California Security Prescription." Moreover, the lot number was not printed on the prescription documents. The prescriptions issued by Dr. M. R. indicated that he worked at Magnolia Urgent Care in Corona, California. However, Magnolia Urgent Care is located in Oxnard, California. The phone number listed on the prescription did not belong to an urgent care clinic. Respondent Chang dispensed all prescriptions written on non-compliant prescription documents outlined in Table Number 5, above.

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33. On February 18, 2021, Respondent Chang provided a written statement to the Board in response to the Board's investigation. As part of her statement, Respondent Chang admitted, "At first I was lury (sic) to fill all these C2 rxs. A lot of patients told me they cannot find a pharmacy to help them. I fill these Rxs with misgivings, reservations and compassion." One of Respondent Covina's staff pharmacists, T. L., also provided a written statement to the Board. With respect to the prescriptions from Dr. J. D., T. L. stated, "I do recall the prescriptions from [Dr. J. D.] because I did notice there were a lot of patients with similar prescriptions. . . . The red flags that I could not clear was (sic) that the patients resided outside the vicinity of Covina and that the doctor's office was out of the vicinity as well. I relied too heavily on the professional history and relationship between the pharmacy and provider and patient."

FIRST CAUSE FOR DISCIPLINE

(Violation of Regulations – Failure to Maintain Dispensing Pharmacist Information)

34. Respondent Covina and Respondent Chang are subject to disciplinary action under Code section 4301, subdivision (o), on the grounds of unprofessional conduct in that they failed to comply with California Code of Regulations, title 16, section 1717 by failing to maintain on file, in readily retrievable form, electronic records of the dispensing pharmacist for each prescription. The dispensing pharmacists' initials recorded in the electronic computer record and on the back of the prescription documents were not accurate, since pharmacists at Respondent Covina frequently utilized Respondent Chang's log-in information when verifying prescriptions. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 22 through 33, inclusive, as though set forth fully herein.

SECOND CAUSE FOR DISCIPLINE

(Violation of Statutes – Dispensing Controlled Substance Prescriptions Written on Insufficient Prescription Documents)

35. Respondent Covina and Respondent Chang are subject to disciplinary action under Code section 4301, subdivisions (j) and (o), on the grounds of unprofessional conduct in that they failed to comply with Health and Safety Code sections 11162.1, subdivisions (a)(2) and (b), and 11164, subdivision (a), in that Respondents dispensed controlled substance prescriptions which

were written on prescription documents lacking a watermark with the words "California Security Prescription" on the backside of the form and lacking a lot number printed on each form. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 22 through 33, inclusive, as though set forth fully herein.

THIRD CAUSE FOR DISCIPLINE

(Corresponding Responsibility)

36. Respondent Covina and Respondent Chang are subject to disciplinary action under Code sections 4301, subdivisions (d), (j) and (o), 4302, and 4113 on the grounds of unprofessional conduct in that they failed to assume their corresponding responsibility to ensure that controlled substances are dispensed for a legitimate medical purpose, in violation of Code section 4306.5, Health and Safety Code section 11153, and California Code of Regulations, title 16, section 1761, subdivisions (a) and (b). Respondents failed to exercise their best professional judgment and evaluate the totality of the circumstances (information from the patient, physician and other sources) to determine a prescription's legitimate medical purpose, in connection with the prescribers' controlled substance prescriptions. Respondents ignored numerous warning signs or red flags in prescriptions from Dr. J. D. that should have put a reasonable and prudent dispensing pharmacist on notice that a prescription may not have been issued for a legitimate medical purpose. Respondents also dispensed 11 prescriptions for the highest strength oxycodone and/or alprazolam to patients who appeared to be opioid or benzodiazepine naïve, as outlined in Paragraph 30, above. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 22 through 33, inclusive, as though set forth fully herein.

OTHER MATTERS

37. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 31167, issued to Covina Pharmacy Incorporated, doing business as Covina Pharmacy, Covina Pharmacy Incorporated shall be prohibited from serving as a manger, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number 31167 is placed on probation or until Pharmacy Permit Number 31167 is reinstated if it is revoked.

38. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 31167, issued to Covina Pharmacy Incorporated, doing business as Covina Pharmacy, while Virginia Chang was an officer and owner and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Virginia Chang shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 31167 is placed on probation or until Pharmacy Permit Number PHY 31167 is reinstated if it is revoked

39. Pursuant to Code section 4307, if discipline is imposed on Pharmacist License Number RPH 31744, issued to Virginia Chang, she shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 317is placed on probation or until Pharmacist License Number RPH 317is reinstated if it is revoked

DISCIPLINE CONSIDERATIONS

40. To determine the degree of discipline, if any, to be imposed on Respondent Covina and Respondent Chang, Complainant alleges that on or about December 4, 1998, in a prior disciplinary action titled In the Matter of the Accusation Against Covina Pharmacy, Inc., doing business as Covina Pharmacy, and Virginia Chang, before the Board of Pharmacy, in Case Number 1882, Respondent Covina's permit and Respondent Chang's license were suspended for one year, with the suspension stayed pending a three-years' probation. Respondent Covina's permit and Respondent Chang's license were disciplined for excessively refiling prescriptions for commonly abused pain medications. That decision is now final.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Pharmacy issue a decision:

1. Revoking or suspending Pharmacy Permit Number PHY 31167, issued to Covina Pharmacy Incorporated, doing business as Covina Pharmacy, Virginia Chang, President and 100% Shareholder;

2. Revoking or suspending Pharmacist License Number RPH 31744, issued to Virginia Chang;

3. Ordering Virginia Chang to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

4. Prohibiting Covina Pharmacy Incorporated from serving as a manager, administrator, owner, member officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 31167 is placed on probation or until Pharmacy Permit Number PHY 31167 is reinstated if Pharmacy Permit Number 31167 issued to Covina Pharmacy Incorporated, doing business as Covina Pharmacy, Virginia Chang, President and 100% Shareholder, is revoked;

5. Prohibiting Virginia Chang from serving as a manager, administrator, owner, member officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 31167 is placed on probation or until Pharmacy Permit Number PHY 31167 is reinstated if Pharmacy Permit Number 31167 issued to Covina Pharmacy Incorporated, doing business as Covina Pharmacy, Virginia Chang, President and 100% Shareholder, is revoked; and

6. Prohibiting Virginia Chang from serving as a manager, administrator, owner, member officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 31744 is placed on probation or until Pharmacist License Number RPH 31744 is reinstated if Pharmacist License Number RPH 31744 issued to Virginia Chang is revoked; and

7. Taking such other and further action as deemed necessary and proper.

DATED: 7/29/2021

Signature on File

ANNE SODERGREN
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
Complainant

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