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Board of Pharmacy News

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The Mission of the Maryland Board of Pharmacy is to protect Maryland consumers and to promote quality health care in the field of pharmacy through licensing pharmacists and registering pharmacy technicians and student interns, issuing permits to pharmacies and distributors, setting pharmacy practice standards and through developing and enforcing regulations and legislation, resolving complaints, and educating the public.

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IS COVID OVER…Really?

Deena Speights-Napata, Executive Director
Chairperson, NABP District 1 and 2

As I think back on the painful memories of the COVID pandemic, and consider evidence from a pandemic that took over 3 million lives —the material evidence of discarded masks that litter the streets and cause our drains to clog, not to mention the emotional impact of the many discarded professional and personal goals. I wonder, will we ever be able to stand within 3 feet of another human being without hesitation? Will we ever feel comfortable the way we used to feel comfortable, sitting in a restaurant or riding the train or flying in a plane? Can we get used to seeing each other's smiles and frowns again instead of just eyes? Can we trust again?

Pharmacists have not been sheltered from experiencing the same feelings and emotions as the general population which often are felt and experienced in the workplace. Some of these challenges include too few pharmacy technicians to assist with the growing demand placed on pharmacies to administer COVID tests and vaccines; too little space for the additional services being provided, and at times an *inability to acquire the social and clinical expertise needed for a successful pharmacy to survive.*

The Board has seen a measurable decrease in the number of registered technicians in Maryland. One of the most measurable factors that has determined the impact of the COVID-19 pandemic on Maryland pharmacies has been seen in the number of technician vacancies and staff turnover being seen across all practice disciplines.

We have also seen another disturbing trend which the board is watching closely. We have seen disparities among Maryland jurisdictions in the number of pharmacy closings. Some of these closings have occurred in jurisdictions already experiencing social and economic disparities. The gradual increases in the number of technician registrations the board has processed recently is a hopeful sign for the future. However, the number and location of pharmacy closings are a concern

The Board of Pharmacy is currently accepting submissions from readers for consideration for upcoming newsletter articles. Desired subjects covered may include public health or general educational topics. Submissions should be 500 words or less, in Microsoft Word document format.

Send any submissions to mdh.mdbop@maryland.gov

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Maryland currently has close to 2100 licensed pharmacies. A review of Maryland pharmacy closings during the calendar years prior to and during COVID revealed that closings nearly doubled in 2021 from 46 closings in 2020 to 71 in 2021. In 2020 close to 1/3 of the closings occurred in the greater Baltimore metro area, and 20% of the closings occurred in Montgomery County. In 2021 Montgomery County experienced the same number of closings that resulted in 12% of the total closings. By contrast the Baltimore metro area experienced a decline in the percentage of closings, weighing in at 25% of the total closings. In 2021 there was a significant increase in the number of pharmacy closings in Howard and Harford counties. The number of closings there were relatively low, but were three times as many as the prior year. Similarly, the percentage of closings in Anne Arundel County, did not represent a significant percentage of the total number of closings, but in 2021 the county experienced twice the number of closings.

Hopefully this year the number of openings will proportionally outnumber the number of closings. Hopefully technician applications and registrations will increase. And hopefully the stress we are all feeling will lessen as we, with confidence and determination, exit the COVID pandemic…really.

PATIENTS Program Receives University of Maryland, Baltimore Diversity Recognition



Pictured: Staff of the PATIENTS Program

During the University of Maryland, Baltimore's (UMB) Rev. Dr. Martin Luther King Jr. and Black History Month Celebration in February, the PATIENTS Program received UMB's 2022 Diversity Recognition Award in the Outstanding Staff category. At the program's core is a mission to conduct patient-centered outcomes research (PCOR) and meet West Baltimore community members where they live, work, or worship. The program was honored for its efforts to stay connected with the West Baltimore community during the COVID-19 pandemic, pivoting its engagement programs and outreach efforts to virtual platforms such as Facebook Live. Working to address barriers preventing city residents from receiving the COVID-19 vaccine, the PATIENTS Program collaborated with a long-term partner, Mount Lebanon Baptist Church, and Walgreens to administer first and second doses to several hundred people.

ImmuNet Reminder

Reminder: When administering a vaccine, a pharmacist may query ImmuNet, Maryland's Immunization Information System, to determine whether a patient has previously received a particular vaccine., This information may be especially important when administering CDC recommended childhood vaccinations.

For more information about ImmuNet and how to access it as an authorized user, please visit the Immunet website at https://health.maryland.gov/phpa/OIDEOR/IMMUN/Pages/immunet-for-health-care-providers.aspx.

Tramadol Revisited

Faisal Syed Minhaj, PharmD
Clinical Toxicology Fellow, Maryland Poison Center

Tramadol was first available in the United States in March 1995 and assigned as a schedule IV substance in 2014. Tramadol is not a strong opioid agonist (~6000x weaker than morphine), but its metabolite, o-desmethyltramadol, has a much higher affinity for the μ-opioid receptor (*Clin Pharmacokinet 2004;43 (13):879-923*). The caveat is that o-desmethyltramadol is formed through metabolism by cytochrome P450 2D6 (CYP 2D6) which is known to have varying activity based on genetic polymorphisms. Caucasians and individuals from the Middle East and Indian subcontinent are more commonly rapid or ultra-rapid CYP 2D6 metabolizers compared to Asian populations and will generate more of the opioid metabolite (*Toxicol Envir Health 12(5-6), 334-61*). Although the parent compound is not an opioid, tramadol shares structural similarities with venlafaxine, and therefore inhibits serotonin and norepinephrine reuptake (SNRI). To quote one toxicologist's thoughts on its mechanism is probably the best way to understand it: it is like giving a patient venlafaxine and morphine in an unknown ratio.

This leads us to the clinical effects that we see in the overdose setting. As odesmethyltramadol functions as an opioid, overdoses may present with miotic pupils, respiratory depression, and central nervous system depression. However, due to the parent compound's SNRI effects, patients can manifest signs and symptoms of serotonin toxicity including tachycardia, agitation, clonus, diaphoresis, and hypertension. This is especially important in patients who are on other serotonergic agents. Additionally, seizures are common in overdoses with frequency usually in the 10–15% range, but in some studies as high as 50–60% (*Arch Acad Emerg Med. 2020 May 17;8(1):e59; Clin Toxicol 57.8 (2019): 692-6*). The smallest dose of tramadol that resulted in a seizure was 200 mg in a 26-year-old male with no history of epilepsy, and 85% of patients who experienced seizures did so within 6 hours of the overdose (*Ann Pharmacother. 2005 Jun;39(6):1039-44*). Another unique effect of tramadol is hypoglycemia which can occur with therapeutic use, seems to be dose related, and those with diabetes, renal insufficiency, and older age appear to be at higher risk (*Ann Pharmacother. 2020 Mar;54(3):247-53*).

Treatment for tramadol overdoses is primarily supportive and dependent on the presenting symptoms. Gastrointestinal decontamination with activated charcoal within 1-2 hours is recommended as opioid effects may delay gastric emptying. If the patient has an opioid toxidrome, treatment with naloxone is indicated. For agitation, tremulousness, and/or seizures, benzodiazepines are the first line therapy. Although there are conflicting reports on naloxone to treat seizures or naloxone causing seizures after tramadol ingestion, it is important to remember that mechanistically, naloxone does not have any antiepileptic properties. The likelihood of patients seizing with tramadol is unrelated to the administration of naloxone and should not preclude naloxone use (*Int J Prev Med. 2019 Oct 9;10:183*).

Tramadol is a unique medication whose effects depend on individual metabolism which are hard to predict. Patients can present with an opioid toxidrome, serotonergic toxicity, along with seizures. Treatment is largely supportive with naloxone, benzodiazepines, and airway management.

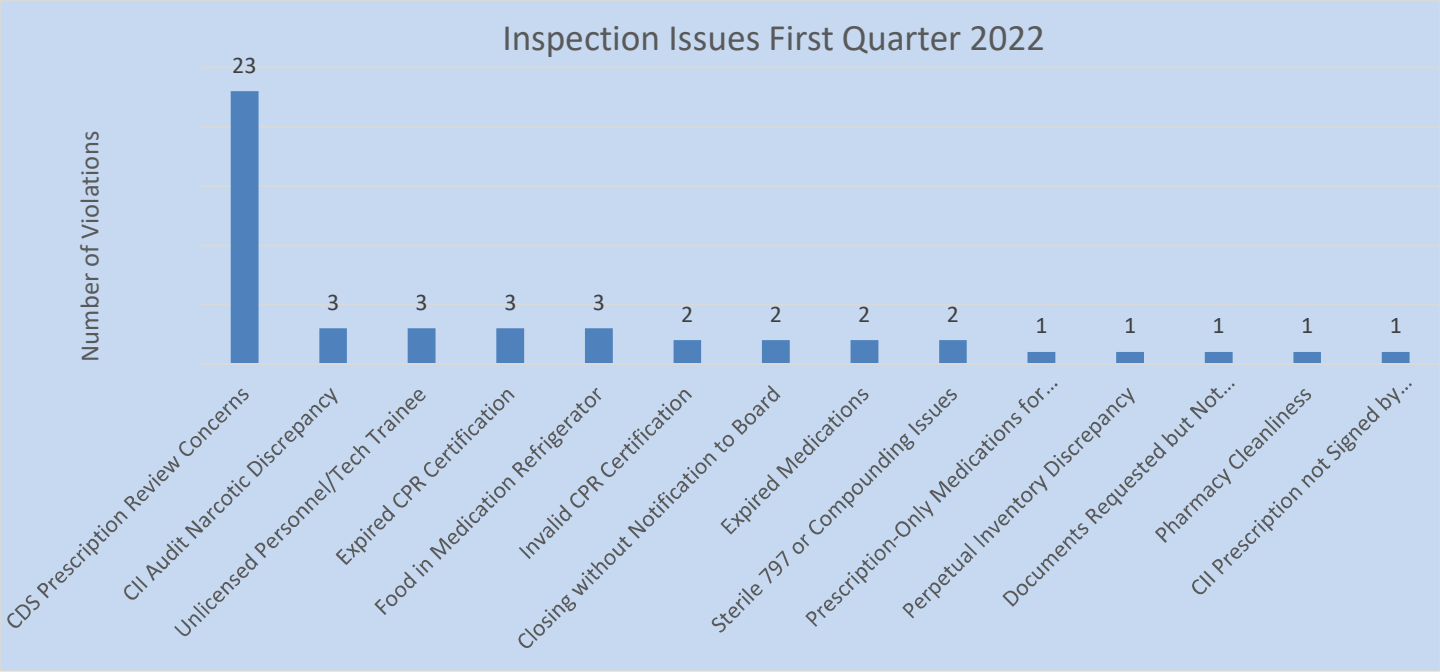
Renewal postcards for pharmacy licenses will no longer be sent out by the Board of Pharmacy. Licensees will instead receive reminder notices by email.

Inspection Issues First Quarter 2022

The Maryland Board of Pharmacy investigates complaints that come to the Board from various sources. Complaints come from consumers, healthcare professionals, pharmacy boards outside of Maryland, federal agencies, and from Board inspections of pharmacies, sterile compounding facilities, and distributors in Maryland. The Board requires that all pharmacies be inspected on an annual basis and distributors be inspected on a biannual basis.

The following **represents** a breakdown of the issues that have come to the Board from the inspection of pharmacies across the state in the first quarter of 2022.

1. CDS Prescription Review Concerns **(23 cases)**
2. CII Audit Narcotic Discrepancy **(3 cases)**
3. Unlicensed Personnel/Tech Trainee **(3 cases)**
4. Expired CPR Certification **(3 cases)**
5. Food in Medication Refrigerator **(3 Cases)**
6. Invalid CPR Certification **(2 cases)**
7. Closing without Notification to Board **(2 cases)**
8. Expired Medications **(2 cases)**
9. Sterile 797 or Compounding Issues **(2 cases)**
10. Prescription-Only Medications for Sale without Pharmacy Permit **(1 case)**
11. Perpetual Inventory Discrepancy **(1 case)**
12. Documents Requested but Not Provided **(1 case)**
13. Pharmacy Cleanliness **(1 case)**
14. CII Prescription not Signed by Prescriber **(1 case)**



Enforcement Postponed of New Mandate for E-Prescribing of CDS

A new law, Health Gen. Article Sec. 21-220, effective January 1, 2022, requires authorized prescribers to issue prescriptions for controlled dangerous substances (CDS) electronically. However, the enforcement of this law is being deferred until January 1, 2023, while the Department of Health promulgates regulations to set out certain criteria for implementation. Notwithstanding the new law, or any postponement of enforcement, pharmacists still maintain their corresponding responsibility to verify that a CDS prescription has been issued for a legitimate medical purpose, whether the prescription format is oral, hard-copy, or electronic.

DISCIPLINARY ACTIONS

PHARMACISTS	LIC. #	SANCTION	DATE
John Barron	26977	Surrender	1/25/2022

PHARMACY TECHNICIANS	LIC. #	SANCTION	DATE
Joevany Martinez	T16956	Probation	12/1/2021
Connie Chou	Applicant	Probation	1/13/2022
Stephanie Allen	T26324	Probation	1/25/2022
Chelsea Booth	T24845	Probation	2/10/2022
Ashley Grimm	T06982	Summary Suspension	3/22/2022
Natasha D. Johnson	T07059	Probation	4/13/2022

National Association of Boards of Pharmacy National Pharmacy Compliance News

Reprinted from the National Association of Boards of Pharmacy FOUNDATION

New Web Page Addresses Boards' Questions on FDA MOU for Compounded Products

Food and Drug Administration (FDA) has created a new web page to help answer questions regarding the *Memorandum of Understanding (MOU) Addressing Certain Distributions of Compounded Human Drug Products* from boards of pharmacy and other state agencies. The web page will continue to be updated by FDA as additional questions on the MOU are received. FDA worked with NABP to develop a standard MOU for use by the state boards of pharmacy to assist with their compliance of section 503A(b)(3)(B)(i) of the Federal Food, Drug, and Cosmetic Act. As part of the MOU, boards must identify pharmacies that are compounding human drug products and distributing inordinate amounts of such products interstate and report those pharmacies to FDA. Additional resources and information on the FDA MOU and the Compounding Pharmacy Information Sharing Project can be found through the Members section of the NABP website.

Pharmacies Can Address These Two Hazards to Improve Safety Programs

This column was prepared by the Institute for Safe Medication Practices (ISMP), an ECRI affiliate. Have you experienced a medication error or close call? Report such incidents in confidence to ISMP's National Medication Errors Reporting Program online at www.ismp.org *or by email to ismpinfo@ismp.org to activate an alert system that reaches manufacturers, the medical community, and Food and Drug Administration (FDA). To read more about the risk reduction strategies that you can put into practice today, subscribe to the ISMP Medication Safety Alert! newsletters at* www.ismp.org.

Every pharmacy should strive to continually improve their medication-use system and provide the safest, highest quality of care possible. To accomplish this, practice sites must assess their risks associated with the medication-use process by monitoring actual and potential medication errors and adverse drug events. Below are two issues that warrant attention and priority if you have not already taken action to mitigate the risk.

Selecting the Wrong Medication After Entering Only the First Few Letters of the Drug Name

Entering just the first few letter characters of a drug name, or a combination of the first few letters and product strength, potentially allows the presentation of similar looking drug names on computer order entry screens. This increases the risk of selection errors. Examples of drug selection errors that resulted after entering the first few letters of the drug name include mix-ups between Ambien® (zolpidem) and ambrisentan; Briviact® (brivaracetam) and Brilinta® (ticagrelor); and tramadol and trazodone. Also, entering "met" has often led to confusion between methylphenidate, methadone, metolazone, methotrexate, metformin, and metronidazole; and entering "meth10" has led to confusion between methadone 10 mg and methylphenidate 10 mg.

Guard against these errors by entering a minimum of the first five letters of a drug name during product searches, which will reduce the number of similar names that appear together on the same screen. Work with your information technology staff and computer vendor to implement this recommendation. Until then, practitioner awareness of this problem may help change personal practice habits.

Daily Instead of Weekly Oral Methotrexate for Non-Oncologic Conditions

Prescribing, dispensing, or administering oral methotrexate daily instead of weekly for non-oncologic conditions continues. A December 2019 *QuarterWatch* analysis of inadvertent daily methotrexate administration over 18 months between 2018 and 2019 demonstrated that about half of the reported errors were made by older patients who were confused

about the frequency of administration, and the other half were made by health care providers who inadvertently prescribed, labeled, or dispensed methotrexate daily when weekly was intended.[1] An analysis sponsored by United States FDA suggests that up to four per 1,000 patients may mistakenly take the drug daily instead of weekly.[2]

Other causes of methotrexate wrong frequency errors more recently reported to ISMP include:

- A mix-up between the look-alike, round, yellow tablets of methotrexate and folic acid, the latter of which is often prescribed with methotrexate to lessen its toxicity
- A fatal mix-up between metolazone 2.5 mg, the intended drug, and methotrexate 2.5 mg, caused in part by entering just "met" into the order entry system and selecting the wrong drug from the search menu
- A fatal mix-up between Paxil® (paroxetine) 10 mg, the intended drug, and Trexall® (methotrexate) 10 mg, caused by mishearing a prescription called in to a community pharmacy

To reduce the risk of error, consider the following strategies:

- implement computer systems that default to a weekly dosage regimen when entering electronic orders or prescriptions for oral methotrexate;
- require an appropriate oncologic indication for all daily methotrexate orders; and
- provide patient and family education about the importance of weekly administration. To assist with education, provide patients and families with a copy of ISMP's free consumer leaflet on oral methotrexate.

References

Moore TJ, Furberg CD, Mattison DR, Cohen MR. QuarterWatch 2019 quarter 2: Scope of injury from therapeutic drugs. Institute for Safe Medication Practices. 4 Dec 2019.

Herrinton LJ, Woodworth TS, Eworuke E, et al. Development of an algorithm to detect methotrexate wrong frequency error using computerized health care data. Pharmacoepidemiol Drug Saf. 2019 Oct;28(10):1361-1368.

Survey: Most Pharmacists Unfamiliar With Safe Online Pharmacy Resources

The results of a survey of United States pharmacists published in the journal *Medicine Access @ Point of Care* indicate that 58% of respondents lacked confidence in identifying and counseling patients on illegal pharmacy websites. Further, fewer than 60% of pharmacists were able to accurately identify whether a web page was legitimate, and 75% of pharmacists reported being unfamiliar with resources available to help consumers identify safe and legitimate online pharmacies.

Pharmacists can help protect consumers who shop for medications online by directing them to always buy from NABP-verified websites. A list of safe online pharmacies and related resources can be found in the Buy Safely section of NABP's consumer website, *www.safe.pharmacy.*

HHS Expands Access Toward Lifesaving Addiction Treatment

The United States Department of Health and Human Services (HHS) has expanded practice guidelines allowing certain practitioners who are state licensed and registered by Drug Enforcement Administration (DEA) to have the ability to more easily prescribe buprenorphine to patients with opioid use disorder (OUD). The expansion scales back the DEA "X-waiver" to further expand patient access to the lifesaving medication. NABP and bipartisan lawmakers continue to push for Congress to pass the Mainstreaming Addiction Treatment Act (MAT Act), which would permanently remove the DEA X-waiver and lay the groundwork for states to utilize pharmacists to provide medication-assisted treatment (MAT).

As part of his 2020-2021 presidential initiative, formerNABP President Timothy D. Fensky, RPh, DPh, FACA, along with NABP and its member boards, have urged Congress to pass the MAT Act to allow states to recognize pharmacists as MAT providers for patients diagnosed with OUD.

Scam Targeting Pharmacists-DEA Warns

Drug Enforcement Administration (DEA) has issued a warning about a scam that is targeting pharmacists in different regions of the United States. In a recent case, a pharmacist received a phone call from an individual who claimed to be from the Federal Bureau of Investigation (FBI) and told the pharmacist that their license was currently under investigation. According to DEA, the scammer warned the pharmacist to not let anyone know about the call and to leave the pharmacy saying they had an urgent family matter, so they could go to the post office to receive faxed details of the FBI investigation. The scammer told the pharmacist that they were being watched and to remain on the phone until receiving the documents at the post office. The pharmacist was also directed to send $18,000 to the scammer.

DEA warns pharmacists to be alert, and that scams can appear in many different forms. Always report anything suspicious to DEA or the FBI.

Nationwide Recall Issued for Acetaminophen Extra Strength Tablets Due to Mislabeling

A-S Medication Solutions, LLC (ASM) is voluntarily recalling 198,350 bottles of acetaminophen extra strength 500 mg tablets, 100-count bottles to the consumer level. The product, which was included in a Health Essentials Kit distributed by Humana to its members, contained an incomplete drug label rather than the required over-the-counter drug facts label.

ASM has been notifying its distributors and customers by mail and arranging the return of all recalled products. Adverse reactions or quality problems experienced with the use of this product may be reported to Food and Drug Administration's MedWatch Adverse Event Reporting program.

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Secretary: **Kristopher Rusinko**	Home Infusion Representative
Treasurer: **Neil Leikach**	Independent Pharmacist Representative
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Surinder Kumar Singal	Independent Pharmacist Representative
Javier Vázquez	Acute Care Hospital Representative
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BOARD MEETINGS

Public Pharmacy Board meetings begin at 9:30am on the third Wednesday of each month and are open to the public. The Board encourages all interested parties to attend the monthly Board Meetings and awards 2 LIVE CEs to all licensees.

2022 PUBLIC BOARD MEETINGS

Third Wednesday of each month

April 20, 2022
May 18, 2022
June 15, 2022

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