



Arkansas State Board of Pharmacy

Published to promote compliance of pharmacy and drug law

101 E Capitol, Suite 218 • Little Rock, AR 72201 • Tel: 501/682-0190 • Fax: 501/682-0195

Compliance with Pharmacist to Pharmacy Technician Ratio

The Arkansas State Board of Pharmacy office has received numerous complaints of violations of **Regulation 03-00-0007 – Pharmacist to Pharmacy Technician Ratio**.

- (a) Retail or Specialty Pharmacy Settings
 - (1) Each pharmacist on duty in a retail or specialty pharmacy may utilize two pharmacy technicians to assist the pharmacist.
 - (2) In addition to the technician(s) described in this section, a pharmacist shall not also supervise more than one student intern. A graduate intern will not affect the ratio.
- (b) Hospital or Ambulatory Care Facility Settings
 - (1) Pharmacy technicians used in assisting the pharmacist in pharmaceutical services for inpatients of the hospital, or patients of an ambulatory care facility shall be permitted to perform under direct supervision of a licensed pharmacist within the following conditions:
 - (A) The number of pharmacy technicians utilized in a hospital pharmacy or ambulatory care facility shall not exceed a ratio of two pharmacy technicians to each pharmacist on duty.
 - (B) This ratio shall not include pharmacy interns counted as either supportive personnel or pharmacists. Also excluded from the count of supportive personnel are those persons whose functions are not related to the preparation or distribution of medication. Such persons include clerks, secretaries, messengers, and delivery personnel. (8/23/96, Revised 10/2000, 8/2001).

This regulation lays out a specific ratio of no more than two technicians performing technician duties for every pharmacist on duty. A pharmacist away from the prescription department

for meal or break time is “not on duty,” as they would not be able to supervise the technician’s work. Those technicians assigned to assist the pharmacist who is away shall not perform technician functions in the pharmacist’s absence. Technician duties in the pharmacy may be as simple a task as the sale of a pseudoephedrine product or the selection of a stock bottle off of a shelf to prepare a prescription. Because such duties may only be made by a pharmacist or technician, the ratio, again, may not be exceeded.

Board inspections have revealed that pharmacies exceed the permissible ratio, oftentimes doing so even after being warned in a previous inspection to remedy the issue. Because exceeding the mandated ratio may result in an unreasonable risk of harm to public health, safety, and welfare, Board staff members have been instructed to increase their vigilance in this area through unannounced inspections and the preparation of cases for public hearing during future Board meetings in order to discipline the licenses of the pharmacist on duty as well as the pharmacist-in-charge, pharmacy permit, and the technician registration for violations.

Long Term Care Prescriptions for Controlled Substances

The Arkansas State Board of Pharmacy office has received dozens of questions regarding changes in Drug Enforcement Administration (DEA) policy regarding the transmission of prescriptions from long term care facilities. After researching DEA’s Web site, their Frequently Asked Questions section may be helpful in answering some of the questions that have recently arisen. The DEA Questions and Answers section contains the following:

Long Term Care Facility (LTCF)

Question: Can controlled substance prescriptions for a resident of an LTCF be faxed to a pharmacy?

Answer: Yes. Schedules II-V controlled substance prescriptions may be transmitted by the

Continued on page 4

NABPCelebrating
30 Years of
Pharmacy
News**30**

1980-2010



National Pharmacy

(Applicability of the contents of articles in the National Pharmacy Compendium and can only be ascertained by examining the original article.)

JCPP 'Future Vision' Sets Course for Advancement of Pharmacy Practice

The Joint Commission of Pharmacy Practitioners (JCPP) brings together the chief executive and chief elected officers of national pharmacy associations, including NABP, to create a forum for discussion and opportunity for collaborative work on issues and priorities of pharmacy practice. Established in 1977, the JCPP meets quarterly and forms workgroups that focus on priority projects. The JCPP has facilitated strategic planning efforts that have shaped positive change in the practice of pharmacy for more than 30 years, and will continue to influence pharmacy practice through its vision articulated in "Future Vision of Pharmacy Practice."

Past Impact

Recommendations resulting from JCPP conferences and quarterly meetings have been aimed to ensure public health and safety by optimizing the medication use process. Working collaboratively through the JCPP, leaders in the profession "acknowledged that the focus of pharmacy must move beyond the important but narrow aspect of 'right drug to the right patient' and encompass the responsibility for assuring that appropriate outcomes are achieved when medications are part of a patient's individual treatment plan." This perception of the function and responsibility of pharmacy practice helped to facilitate changes such as the shift to a universal doctoral level of education, and practice and legal changes that have helped pharmacists to increase their scope of services.

Also as a result of JCPP collaborations, coalitions among pharmacy organizations and other stakeholders have been formed, and have helped to shape new state and national legislation and regulations. For example, JCPP coalitions helped influence changes that resulted in Medicare's prescription drug benefit requirement for medication therapy management services as of 2006.

Future Impact

Through the "Future Vision of Pharmacy Practice," adopted by JCPP member organization executive officers in 2004, the JCPP will continue to influence positive change in the practice well into the next decade. The JCPP "Future Vision of Pharmacy Practice," endorsed by each JCPP member organization's board of directors, envisions what pharmacy practice should look like in 2015, as summarized in the document's opening statement: "Pharmacists will be the health care professionals responsible for providing patient care that ensures optimal medication therapy outcomes."

In his incoming speech at the NABP 105th Annual Meeting in May 2009, President Gary A. Schnabel, RN, RPh, endorsed the future vision outlined in the JCPP "Future Vision of Pharmacy Practice," stating, "As boards of pharmacy, I feel that it is also imperative for us to embrace this future vision, and through our statutes and regulations define and advance that vision in the context of patient care and protection of the public health . . . If the boards of pharmacy can provide the regulatory environment that fosters the vision on behalf of the patient and the protection of the public health, then this collective vision of practitioners and regulators will serve as one of the pillars of a new foundation for the practice of pharmacy first proposed some 30 years ago and discussed ad nauseam every year since those words were first spoken and captured in the pharmacy journals."

The 2015 future vision is detailed in the document in three sections: the foundations of pharmacy practice, how pharmacists will practice, and how pharmacy practice will benefit society. The first section outlines the foundations of pharmacy education that prepares pharmacists

"to provide patient-centered and population-based care that optimizes medication therapy." The second section explains that the pharmacist's scope is to include managing medication therapy, accounting for patients' therapeutic outcomes, and promoting patient wellness. The section also emphasizes that as they work with other health care professionals, pharmacists will be the most trusted source of medications and supplies, and the primary resource for advice regarding medication use. Finally, the last section stresses that, by realizing the expanded scope of their practice, pharmacists will achieve public recognition as practitioners who are essential to providing effective health care.

In January 2008, the JCPP released the final version of "An Action Plan for Implementation of the JCPP Future Vision of Pharmacy Practice," which identifies three critical areas for initial focus as it works toward achieving the vision. JCPP anticipates more discussions to help align the action steps of the implementation plan and the policies of participating organizations. Thus, in keeping with the organization's mission, JCPP continues to implement its initiatives, including the "Future Vision of Pharmacy Practice," through the collaborative efforts it fosters.

The JCPP's "Future Vision of Pharmacy Practice" and "An Action Plan for Implementation of the JCPP Future Vision of Pharmacy Practice" can be downloaded from the National Alliance of State Pharmacy Associations' Web site at www.naspa.us/vision.html.

ISMP Stresses Need to Remove Non-Metric Measurements on Prescriptions and on Patient Labels to Prevent Error



This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency that analyzes medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, and publishes its recommendations. To read about the risk reduction strategies that you can put into practice today, subscribe to ISMP Medication Safety Alert!® Community/Ambulatory Care Edition by visiting www.ismp.org. ISMP is a federally certified patient safety organization, providing legal protection and confidentiality for submitted patient safety data and error reports. ISMP is also a FDA MedWatch partner. Call 1-800-FAIL-SAF(E) to report medication errors to the ISMP Medication Errors Reporting Program or report online at www.ismp.org. ISMP address: 200 Lakeside Dr, Suite 200, Horsham, PA 19044. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.

ISMP is calling upon prescribers, pharmacists, and other health care professionals, as well as pharmacy computer system and e-prescribing system vendors, to remove or prevent the use of "teaspoonful" and other non-metric measurements in prescription directions in order to better protect patients.

In the past, mix-ups involving confusion between measuring medications in milliliters or teaspoonfuls and other non-metric measurements have resulted in the serious injury of children and adults.

These mistakes continue to happen. ISMP has received more than 30 reports of milliliter-teaspoonful mix-ups, including cases where injuries required treatment or hospitalization. In one case, a child who recently had surgery was seen in an emergency department and later was admitted with respiratory distress following an unintentional overdose of acetaminophen and codeine liquid. The pharmacy-generated label on the child's medication bottle instructed the parents to give the child six



teaspoonfuls of liquid every four hours. The original prescriber stated the prescription was for 6 mL. The child received five doses before arriving at the emergency department.

In a second case, a child received an overdose of the antifungal medication Diflucan® (fluconazole) suspension. The physician phoned a prescription for Diflucan 25 mg/day to a community pharmacy for a three-month-old child with thrush. The pharmacist dispensed Diflucan 10 mg/mL. The directions read "Give 2.5 teaspoons daily." The directions should have read "Give 2.5 mL daily." Prior to the error, the child had been ill for the previous three weeks with an upper respiratory infection, nausea, vomiting, and diarrhea. It is suspected that the child's subsequent hospitalization was related to this error.

ISMP Safe Practice Recommendations

The health care industry – including practitioners and computer vendors – needs to acknowledge the risk of confusion when using non-metric measurements, especially with oral liquid medications. Steps, like the following ISMP recommendations, must be taken to prevent errors:

- ◆ Cease use of patient instructions that use "teaspoonful" and other non-metric measurements, including any listed in pharmacy computer systems. This should include mnemonics, speed codes, or any defaults used to generate prescriptions and labels.
- ◆ Express doses for oral liquids using only metric weight or volume (eg, mg or mL) – never household measures, which also measure volume inaccurately.
- ◆ Take steps to ensure patients have an appropriate device to measure oral liquid volumes in milliliters.
- ◆ Coach patients on how to use and clean measuring devices; use the "teach back" approach, and ask patients or caregivers to demonstrate their understanding.

The *Model State Pharmacy Act* and *Model Rules of the National Association of Boards of Pharmacy's (Model Act)* labeling provisions state that the directions of use language should be simplified, and when applicable, to use numeric instead of alphabetic characters such as 5 mL instead of five mL. The *Model Act* also provides for the pharmacist to personally initiate counseling for all new prescriptions, which can decrease patient injuries due to improper dosing.

Clarification on HIPAA Regulations and Claims Submission

NABP received questions about a statement that appeared in the article, "Concerns with Patients' Use of More than One Pharmacy," published in the 2009 fourth quarter *National Pharmacy Compliance News* which read, "Community pharmacists can help by submitting claims to insurance carriers, as cash, to keep an accurate medication profile for the patient."

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR 164.501) establishes a foundation of federal protection for personal health information with which health care practitioners must comply. To avoid interfering with a patient's access to, or the efficient payment of quality health care, the privacy rule permits a covered entity, such as a pharmacy, to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities. The rule includes the determination of eligibility or coverage and utilization review activities as examples of common payment activities, therefore allowing a pharmacist to submit cash claims. Additional information may be found at www.hhs.gov/ocr/

[privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html](http://www.nabp.net/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html).

Pharmacists should, however, verify with their state boards of pharmacy as to whether there are existing state laws that prohibit this practice.

State Newsletter Program Celebrates 30 Years of News on Pharmacy Regulation

This year, the NABP State Newsletter Program celebrates its 30th anniversary of partnering with the boards of pharmacy to provide pharmacists with vital information about their state's pharmacy laws and regulations.

The State Newsletter Program, which is part of the NABP Foundation, was developed to support the Association's educational programs and research and development projects. Published on a quarterly basis, the program serves the state boards of pharmacy by communicating board information to pharmacists, pharmacy technicians, pharmacies, and others throughout the pharmacy profession.

The goal of the State Newsletter Program was, to improve communications with practitioners regarding federal and state law, this allowing them to comply with the law on a voluntary basis, demonstrating that an informed and responsible professional is one of the most effective means of protecting the public health.

In addition to the news provided by the boards of pharmacy, a copy of the *National Pharmacy Compliance News* is included in each issue. Published quarterly by NABP, *National Pharmacy Compliance News* provides important news and alerts from the federal Food and Drug Administration, Drug Enforcement Administration, the Centers for Medicare and Medicaid Services, Consumer Product Safety Commission, and ISMP, as well as current national developments affecting pharmacy practice.

Using *National Pharmacy Compliance News*, merged with locally developed state news, a total of 16 states joined the program in its original summer 1979 publication, including 13 states that still participate today: Arizona, Arkansas, Delaware, Idaho, Kansas, Kentucky, Montana, Minnesota, North Carolina, Ohio, Oregon, South Carolina, and Washington.

Today, 31 states participate in the program. Of these, 18 state boards of pharmacy publish electronic newsletters rather than printed newsletters. The e-newsletter option was implemented in 2004, and has allowed boards with limited resources the opportunity to communicate important board information in a timely and cost-effective manner. State e-newsletters are posted on the NABP Web site rather than published by a printer; the board may also post the Newsletter to their Web site.

In 2006, the e-newsletter portion of the program was enhanced and NABP began offering the boards an e-mail alert service. The e-newsletter e-mail alert service, which consists of an e-mail notification that is sent through a state-specific e-mail database, is provided free of charge to participating state boards of pharmacy. Each alert notifies recipients that the e-newsletter is now available to download and provides a link to access the board's newsletter. The Arizona State Board of Pharmacy was the first state to utilize this free service, and now the number of participating boards has grown to 12 states.

All NABP Foundation State Newsletters, including a copy of the *National Pharmacy Compliance News*, are available on the NABP Web site at www.nabp.net. Please note, years prior to 2000 are only available in hard copy form, and therefore, cannot be downloaded online. For more information about the NABP State Newsletter Program, contact custserv@nabp.net.

practitioner or the practitioner's agent to the dispensing pharmacy by facsimile. The facsimile serves as the original written prescription.

Question: Can an LTCF store controlled substances in an emergency kit without being registered with DEA?

Answer: DEA published the following Statement of Policy in the April 9, 1980 Federal Register regarding the placement of controlled substances in an emergency kit located in an LTCF.

Statement of Policy

The placement of emergency kits containing controlled substances in **non-federally** registered Long Term Care Facilities (LTCF) shall be deemed to be in compliance with the Comprehensive Drug Abuse Prevention and Control Act of 1970, if the appropriate state agency or regulatory authority specifically approves such placement and promulgates procedures which delineate:

- A. The source from which an LTCF may obtain controlled substances for emergency kits. The source of supply must be a DEA registered hospital/clinic, pharmacy, or practitioner.
- B. Security safeguards for each emergency kit stored in the LTCF which include the designation of individuals who may have access to the emergency kits and a specific limitation of the type and quantity of controlled substances permitted to be placed in each emergency kit.
- C. Responsibility for proper control and accountability of such emergency kits within the LTCF to include the requirement that the LTCF and the providing DEA registered hospital/clinic, pharmacy, or practitioner maintain complete and accurate records of the controlled substances placed in the emergency kit, the disposition of these controlled substances plus the requirement to take periodic physical inventories.
- D. The emergency medical conditions under which the controlled substances may be administered to patients in the LTCF to include the requirement that medication be administered by authorized personnel only as expressly authorized by an individual practitioner and in compliance with the provisions of 21 CFR 1306.11 and 21 CFR 1306.21.
- E. Prohibited activities which can result in the state revocation, denial, or suspension of the privilege of having or placing emergency kits, containing controlled substances, in an LTCF.

Information copied directly from the United States Department of Justice, Drug Enforcement Administration, Office of Diversion Control Web site in the General Questions

& Answers section on April 2, 2010, www.deadiversion.usdoj.gov/faq/general.htm#t-1.

The Board recognizes that this is a point of great confusion for pharmacies and pharmacists and even discussed this topic during the March 10, 2010 meeting, passing a motion to re-emphasize the fact that the Arkansas State Board of Pharmacy continues to recognize longstanding regulations for the state of Arkansas as follows.

Regulation 7 – Drug Products/Prescriptions

07-00: General Regulations Regarding Drugs/Prescriptions

07-00-0001—Facsimile (Fax) Prescription Drug Order

A prescription drug order which is transmitted by an electronic device which sends an exact copy image to the receiver (pharmacy) over telephone lines.

(b) Faxing from a long-term-care facility to a pharmacy – a pharmacist may accept a fax prescription from a long-term-care facility provided:

- (1) For Schedule II drugs, all requirements of a written prescription are met, including the prescriber's signature on the faxed order and it is faxed by the nurse/person the physician and the long-term-care facility has designated as his/her "agent" to transmit the order, and must contain the nurse/person's signature.
- (2) For drugs other than Schedule II, the order is faxed by the nurse/person the physician and the long-term-care facility has designated as his/her "agent" to transmit the order, and must contain the nurse/person's signature.
- (3) The pharmacist verifies the fax is from the machine in the long-term-care facility.

(c) Faxed prescriptions

- (1) A pharmacist may dispense directly a controlled substance listed in Schedule III, IV, or V which is a prescription drug, or any legend drug, only pursuant to either a written prescription signed by a prescribing individual practitioner or a facsimile of a written signed prescription transmitted directly by the prescribing practitioner, or the practitioner's agent, to the pharmacy or pursuant to an oral prescription made by a prescribing individual practitioner, or the practitioner's agent, and promptly reduced to writing by the pharmacist.
- (2) All law and regulation applicable to oral prescription drug orders shall also apply to all facsimile orders including, but not limited to, generic substitution, maintenance of records, information required, etc.

- (3) A prescription order transmitted by facsimile device shall contain all prescription information required by federal and state law.
- (4) A pharmacist may dispense new prescription orders transmitted by fax only when signed by the prescribing practitioner and transmitted from the practitioner's office or a long-term-care facility in compliance with all sections of this document. Any faxed new prescription order that is not signed must be treated as a verbal order and verified to the pharmacist's satisfaction that it is legitimate.
- (5) The original fax shall be assigned the number of the prescription dispensed, and maintained in pharmacy records for at least two years.
- (6) The receiving fax machine must be in the prescription department of the pharmacy to protect patient/pharmacist authorized prescribing practitioner confidentiality and security.
- (7) Refill authorizations for prescriptions, other than Schedule II, may be transmitted using a facsimile device. Any faxed authorization to renew or refill a prescription that is not signed must be treated as a verbal order and verified to the pharmacist's satisfaction that it is legitimate.

(10/12/93 Amended 2/15/95, 10/14/1997 and 7/10/2009)

It is also important to note that DEA rules only affect controlled substances and that any changes to DEA policy have no effect on non-controlled substances.

Monitor, Secure, and Dispose – How Patients Should Know What They Are Taking, Secure Their Prescription Medications, and Properly Dispose of Prescription Drugs

On March 12, 2010, the Arkansas Drug Director, Fran Flener, kicked off a collaborative media, education, and law enforcement prevention campaign of Monitor, Secure, and Dispose to help address the growing problem of prescription drug abuse in Arkansas. Recent findings reported by Partnership for a Drug-Free America indicate that every day more than 2,500 youth, ages 12 to 17, abuse prescription drugs for the first time. The National Survey on Drug Use and Health as reported by the Substance Abuse and Mental Health Services Administration (SAMHSA), indicates that more than 2.1 million youth in the same age group reported abusing prescription drugs in 2008 – and among 12- and 13-year-olds, prescription drugs are the drug of choice. DEA reports that prescription drug abuse exceeds the use of heroin, cocaine, and hallucinogens combined.

Unfortunately, Arkansas leads the nation in this escalating threat to the health and welfare of our children. According to the Office of National Drug Control Policy's (ONDCP) 2007 *Teens and Prescription Drugs* report, Arkansas has the worst teen prescription pain reliever abuse problem in the entire US.

In 2008, the Arkansas Prevention Needs Assessment (APNA) reported that 22% of Arkansas high school students have abused prescription drugs by the time they reach their senior year. Additionally, they found that close to 10% of Arkansas high school seniors reported non-medical use of prescription drugs in the past 30 days and also discovered that Arkansas sixth graders abuse prescription drugs more than any other substance except alcohol and cigarettes.

Because most teens are freely provided with or steal these drugs from parents, grandparents, or friends, this campaign is designed to provide key information on how to properly monitor, secure, and dispose of commonly abused and other medicines and to raise awareness of teen prescription drug abuse.

Most pharmacists recognize that prescription drug abuse is growing exponentially. Part of this is due to the assumption that prescription medications are "safe and effective" since they are approved by Food and Drug Administration (FDA). Unfortunately, most young people do not think about or realize the risks associated with misuse and abuse. When prescription medications are not used according to precise instructions and with appropriate oversight by medical professionals, the risk of side effects, addiction, and even death are greatly multiplied.

"It's crucial that we take preventative measures," said Fran Flener, Arkansas drug director. "We need to treat our medications as we would fine jewelry or a loaded gun. There are so many things parents can do to prevent their kids from having these problems, starting with controlling their own medications. The most important resource a child has in deciding to be drug-free is his or her parents."

Pharmacists are routinely asked questions regarding the appropriate disposal of medications. The "Monitor, Secure, Dispose" message is a simple way to educate our fellow Arkansans and especially your patients about this growing problem and its dangers, and it is easy for everyone to participate. Following are these key steps for patients.

First, monitor your medications. Take note of how many pills are in each bottle or packet and keep track of your refills.

Second, secure your medications – both prescription and over-the-counter. Keep them in a safe place where youth cannot access them. Lock them away if necessary. Encourage other adults to secure their medications as well.

Third, dispose of unneeded, unused, and outdated medications. Most drugs should be thrown in the trash after mixing the medication with an undesirable substance such as used coffee grounds, kitty litter, or dirt. However, FDA recommends some medications be flushed. If you need more information about disposal of medications, please refer to the SMARxT Disposal at www.smarxtdisposal.net or contact FDA at 1-888/INFO-FDA (1-888/463-6332). Additionally, remove any personal, identifiable information from the bottles or packages before throwing them away to prevent unauthorized refills.

It is vital to help people increase awareness regarding what medications they have in their homes, inform them how to se-

cure their medications, and inform them how to appropriately dispose of their medications when they are no longer needed. These three steps could help prevent countless problems and potential injuries or death from prescription drug abuse. You can also refer to the Web site, www.ioit2me.com, for information regarding drug abuse that may be beneficial to parents and teens.

The Growing Problem of Prescription Drug Abuse

- ◆ Arkansas has the worst teen prescription pain reliever abuse problem in the entire US. (SAMHSA, 2007, as reported in ONDCP *Teens and Prescription Drugs* report, February 2007)
- ◆ By the time Arkansas high school students have reached their senior year, 22% have abused prescription drugs. (APNA, 2008)
- ◆ Close to 10% of Arkansas high school seniors reported non-medical use of prescription drugs in the past 30 days. (APNA, 2008)
- ◆ Arkansas **sixth graders** abuse prescription drugs more than any other substance except alcohol and cigarettes. (APNA, 2008)
- ◆ Over-the-counter and prescription drug abuse is rapidly increasing in earlier grades and at a rate comparable to, but **faster** than alcohol and cigarettes. (Division of Behavioral Health Services (DBHS), Special Report on Over the Counter and Prescription Drug Use Among Arkansas Students, unreleased)
- ◆ In 2007, the rate of past 30-day sedative use among Arkansas youth was roughly three times that of the national rate (DBHS, APNA, 2007, and National Institute on Drug Abuse (NIDA), *Monitoring the Future*, 2007)
- ◆ Arkansas has consistently ranked among the 10 states with the highest rate of non-medical use of pain relievers by 12 to 20-year-old individuals since state estimates of this measure first began in 2002. (SAMHSA, Office of Applied Studies, Short Report on Substance Abuse and Mental Health Issues – Arkansas, December 2008).

- ◆ Nationwide, prescription pain relievers have more first-time users than any illicit drug, including marijuana, cocaine, ecstasy, inhalants, LSD, methamphetamine, heroin, and PCP. (SAMHSA, National Survey on Drug Use and Health, 2007)
- ◆ Seven of the 10 drugs most abused by high school seniors are prescription or over-the-counter drugs acquired primarily from teens' friends or relatives. (NIDA, *Monitoring the Future*, 2009)

For more information, please visit www.ioit2me.com.

Special Notice about the Arkansas State Board of Pharmacy Newsletter

The Arkansas State Board of Pharmacy has designated this *Newsletter* as an official method to notify pharmacists licensed by the Board about information and legal developments. Please read this *Newsletter* and keep it for future reference because this *Newsletter* will be used in hearings as proof of notification of the *Newsletter's* contents. Please contact the Board Office (501/682-0190) if you have questions about any of the articles in this Newsletter.

Arkansas Pharmacy Support Group Help Line

870/636-0923

Page 6 – May 2010

The *Arkansas State Board of Pharmacy News* is published by the Arkansas State Board of Pharmacy and the National Association of Boards of Pharmacy Foundation, Inc, to promote compliance of pharmacy and drug law. The opinions and views expressed in this publication do not necessarily reflect the official views, opinions, or policies of the Foundation or the Board unless expressly so stated.

John Kirtley, PharmD - State News Editor

Carmen A. Catizone, MS, RPh, DPh - National News Editor
& Executive Editor

Larissa Doucette - Communications Manager

Presorted Standard
U.S. Postage
PAID
Chicago, Illinois
Permit No. 5744

ARKANSAS STATE BOARD OF PHARMACY

National Association of Boards of Pharmacy Foundation, Inc
1600 Feehanville Drive
Mount Prospect, IL 60056