November 2013

News

Arkansas State Board of Pharmacy

Published to promote compliance of pharmacy and drug law

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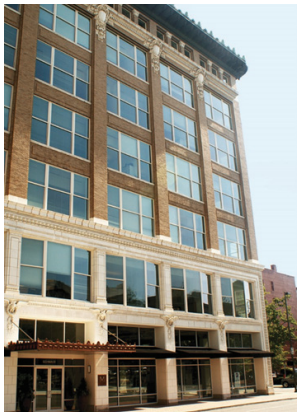
New Web Site

The Arkansas State Board of Pharmacy has a new Web site: *http://pharmacyboard.arkansas.gov.*

New Offices and Location for the Board

The Board has moved into new offices with an updated address. While its previous space served it very well for the 20 years that the Board was located there, this move provides the Board with much needed space for its Board meetings as well as collaborating with interprofessional workgroups on issues such as prescription drug abuse, prescription drug take-back programs, law tests, law reviews, and educational opportunities delivered from the Board staff. The Board is already using its new conference room in this capacity and looked forward to its first full Board meeting during October in its new Board room. As a reminder, a few of the benefits of this new space include being Americans with Disabilities Act compliant, better security, a Board room that can seat 75, a testing classroom for up to 60, a conference room, and an office space for the Board's attorney when the Board is working on cases or legal issues. The new address is:

Arkansas State Board of Pharmacy
322 South Main Street, Suite 600
Little Rock, AR 72201



Some of you were able to attend its first Board meeting in the new facility on October 8-9, 2013, where the Board also hosted an open house to see the new offices on the afternoon of October 9. The Board hopes that you will consider attending future meetings and continuing education (CE) offerings in its offices as these opportunities arise.

Kevin Robertson, PharmD, BCPS, Appointed to Board

Governor Mike Beebe appointed Dr Kevin Robertson to the Board on June 30, 2013, to replace Ronnie Norris of McGehee, AR.

Dr Robertson earned his doctor of pharmacy degree from the University of Arkansas for Medical Sciences (UAMS) in 1996. He completed his American Society of Health-System Pharmacists (ASHP)-accredited pharmacy practice residency at Methodist Hospitals of Memphis in Memphis, TN, in 1997. He is board certified in pharmacotherapy by the Board of Pharmacy Specialties.

Dr Robertson has experience in ambulatory and acute care pharmacy services. His past professional work includes a five-year tenure as a clinical pharmacist/pharmacy informatics specialist at Saline Memorial Hospital in Benton, AR. He currently serves as the clinical coordinator and residency program director at Baptist Health Medical Center – North Little Rock, AR. Dr Robertson is a clinical assistant professor for the UAMS College of Pharmacy as well as a member of ASHP, American College of Clinical Pharmacy, Arkansas Pharmacists Association, and Arkansas Association of Health-System Pharmacists.

Dr Robertson has served as a pharmacist volunteer for the Harmony Health Clinic in Little Rock, AR, since 2011 and as an advanced pharmacy practice experience management preceptor for the UAMS College of Pharmacy and Harding University College of Pharmacy. Dr Robertson and his wife, Tonya, who is also a pharmacist, live in Little Rock.

Dr Norris served on the Board for 12 years bringing a wealth of knowledge with his experience not only as a hospital pharmacist but also as a pharmacy owner in McGehee. Dr Norris's sense of service to the community and his quick wit will be missed.

Arkansas Prescription Monitoring Program

The Arkansas Prescription Monitoring Program (PMP) has been operational for a few months now and because many of you may have questions on this program, this is an excellent time to provide some answers and/or pointers for dealing with the PMP system. One important point is that the information being fed into the PMP system must be accurate. The saying "trash in = trash out" is quite appropriate in this sense and it is very important that the identifying information for patients as well as prescribers be accurate. This is a point

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Pharmacists Likely to Recommend OTC Medications, CHPA Reports

Patients most often seek a pharmacist's advice on treating coughs, headaches, migraines, and allergies, and 98% of pharmacists recommend or have no reservations recommending over-the-counter (OTC) products to treat such ailments, according to a recent survey. The Consumer Healthcare Products Association's (CHPA) report, "Understanding Trust in OTC Medicines: Consumers and Healthcare Provider Perspectives," presents the results of the survey, which was developed to better understand what drives consumer and health care provider trust in OTC products. The survey, developed and conducted by Nielsen and IMS, included over 1,100 consumer respondents, and over 500 health care provider respondents, composed of pharmacists, pediatricians, nurse practitioners, and primary care providers.

Pharmacists surveyed reported that they were more likely to recommend OTC products that demonstrated successful patient outcomes and consistent outcomes, and products known to be as efficacious as a prescription drug, and those containing ingredients known to be safe.

The survey also asked health care providers whether they recommended OTC products without, before, or in conjunction with recommending prescription drugs for certain symptoms. A majority of pharmacists surveyed, over 60%, recommend OTC medications to treat stomach symptoms and pain, without recommending a prescription treatment, and over 70% recommended OTC allergy, sinus, and flu medications without advising that a prescription drug is needed.

CHPA notes that with the expansion of patient self-care, OTC products will play an increasingly important role in health care. The potential for more prescription products to become OTC products in the new paradigm under consideration by Food and Drug Administration (FDA) could further impact this trend. As consumers are becoming more empowered in making health care decisions, they are also relying more on their pharmacist for medication advice. In fact, Nielsen and IMS findings show that multigenerational households, Hispanic households, and households who care for an adult outside of their home place a high value on pharmacist recommendations regarding selecting appropriate OTC medications, notes CHPA.

The full CHPA White Paper is available at *www.yourhealthathand.org/images/uploads/OTC_Trust_Survey_White_Paper.pdf*.

ISMP Study on Targeted Mandatory Patient Counseling

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 an 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.*

In a recent study funded by a grant from Agency for Healthcare Research and Quality, ISMP evaluated the use of a combined checklist and patient information leaflet used during mandatory counseling sessions for consumers who pick up a filled prescription for 11 targeted medications:

- Opioid-containing analgesics
  - fentanyl patches
  - hydrocodone with acetaminophen
  - oxycodone with acetaminophen
- Anticoagulants
  - warfarin
  - enoxaparin
- Antidiabetic drugs (insulin analogs)
  - Humalog® (insulin lispro)
  - NovoLog® (insulin aspart)
  - Levemir® (insulin detemir)
  - Lantus® (insulin glargine)
  - Apidra® (insulin glulisine)
- Antineoplastic drug (non-oncologic use)
  - methotrexate

All 11 medications are on ISMP's list of high-alert medications dispensed from community pharmacies. Errors with high-alert medications may not be more frequent than errors with other medications; however, the consequences of errors with high-alert medications are often harmful. These 11 medications are also among the top 200 drugs dispensed in the United States, and many are used to treat chronic conditions, thus increasing the potential impact on public safety.

The medications were flagged in some manner to identify mandatory counseling opportunities. When a patient or patient representative picked up a flagged prescription, a pharmacist conducted a short counseling session (one to three minutes) that included the exchange of several key points on the checklist. At the end of the counseling session, the pharmacist provided the leaflet to the patient, along with a survey to complete and send back to ISMP.

Counseling sessions for these drugs were conducted for a consecutive period of four weeks, during which time, one trained ISMP staff member observed the counseling sessions for one day (six hours) to collect information on factors that facilitate or inhibit the counseling sessions. At the end of the four-week period of mandatory counseling, pharmacists at participating pharmacies were asked to complete a short mail-in survey regarding their perceived value of the process.

Results of the study showed that these consumer leaflets offer important safety tips for taking medication safely. Each leaflet begins with, "High-alert medicines have been proven to be safe and effective. But these medicines can cause serious injury if a mistake happens while taking them. This means that it is vitally important for you to know about this medicine and take it exactly as intended."

ISMP tested the readability, usability, and perceived value of the leaflets. Ninety-four percent of patients felt the leaflets provided great information or good information to know. Ninety-seven percent felt the information in the leaflets was provided in a way they could understand. Eighty-two percent of patients taking the drug for the first time and 48% of patients who had previously taken the medication reported learning something new. Overall, 85% of the patients felt they were less likely to make a mistake with the medication because they had read the leaflet.

The leaflets are available for download and can be reproduced for free distribution to consumers at *www.ismp.org/AHRQ/default.asp?link=ha.*

Generic Drug Substitution Requires Pharmacist Attention to State Laws and Regulations

While 40 years ago, most states forbade prescription drug substitution, almost all states now have drug product selection laws that allow, encourage, or mandate pharmacists to substitute generics for brand-name drugs. These laws vary widely from state to state and pharmacists are therefore encouraged to review their state's substitution laws to ensure that they understand and comply with the state's requirements.

FDA's *Approved Drug Products With Therapeutic Equivalence Evaluations* publication, commonly known as the *Orange Book,* is generally considered the primary source for identifying suitable generic alternatives for a brand-name drug, and while not mandated by FDA regulations, the majority of states use the *Orange Book's* determinations of therapeutic equivalence to legally guide pharmacists in substituting generics.

State laws on generic substitution vary widely. A few states, such as Kentucky or Minnesota, follow a "negative formulary" approach, in which substitution is permitted for all drugs except those that appear on a particular list. Other states, including Massachusetts and Wisconsin, use a "positive formulary" approach, in which substitution is limited to the drugs on a particular list.

States also differ as to whether their substitution laws are permissive, thereby allowing a pharmacist to substitute a generic version of a brand-name drug, provided all prescription requirements are met, or mandatory, thereby requiring substitution. Prescription requirements may include such factors as the availability of a cheaper, therapeutically equivalent drug, the prescriber's specification that a brand-name drug be dispensed, or requiring the patient's or prescriber's consent. As reported in the 2013 NABP *Survey of Pharmacy Law*, 14 boards of pharmacy indicate that generic substitution falls into the "mandatory" category, while 38 boards indicate that their substitution laws are "permissive." Oklahoma law states that "[I]t is unlawful for a pharmacist to substitute without the authority of the prescriber or purchaser."

Other regulatory variations include states specifying the acceptable means for the prescriber to designate that substitution is not authorized, and states requiring patient consent prior to substitution.

The full article on this subject, which also reviews considerations regarding the accuracy of therapeutic equivalent determinations, is available in the June-July 2013 *NABP Newsletter,* which may be accessed in the Publications section of *www.nabp.net.*

NHF Provides Standards of Care for Pharmacies Serving Hemophilia Patients

For pharmacies that offer blood-clotting medications, organizations such as the National Hemophilia Foundation (NHF) emphasize the importance of being able to meet the specialized needs of their patients with bleeding disorders.

NHF's Medical and Scientific Advisory Council (MASAC) issued a standards-of-care recommendation in 2008 to assist pharmacies providing clotting factor concentrates for home use to patients with bleeding disorders. MASAC's guidelines are intended to be minimum standards of care and are divided into six areas:

As a brief overview of the MASAC guidelines, pharmacists wishing to meet the standards should:

1. Have a basic knowledge of bleeding disorders and experience with and knowledge of the full range of clotting factor concentrates, ancillary supplies, and hazardous waste disposal.

Pharmacies wishing to meet MASAC standards:

2. Should be able to provide a full range of available concentrates in all available assays and vial sizes, along with all necessary ancillary supplies, and hazardous waste disposal assistance as well as access to nursing services.
3. Should support reliable access to clotting factor for appropriate home treatment, by filling prescription orders within 48 hours, in the quantities prescribed, with expiration dates commensurate with the individual patient's needs.
4. Should be reliably open during regular business hours; provide 24-hour emergency access; and have an emergency action plan that allows patients to receive factor within 12 hours "in case of emergent need," with a goal of three hours "where logistically possible."
5. Should deliver products to the patient's desired location, meeting federal medication shipping standards, and providing an emergency number for patients to call in case of a problem with a delivery.
6. Should maintain patients' treatment prescription information along with maintaining records in compliance with state and federal requirements and be able to track the clotting factor products from manufacturer to patient, and participate in a recall information system.

The full article on this topic is available in the June-July 2013 *NABP Newsletter,* accessible in the Publications section of *www.nabp.net.* NABP notes that each state needs to review the standards recommended by MASAC to determine whether they coincide with existing state board of pharmacy requirements. NABP recognizes the unique patient needs of hemophiliacs, but also the responsibility of state boards of pharmacy to set required standards for medication dispensing and use. NABP is working with NHF to help the boards of pharmacy gain a better understanding of the medication needs of patients to help achieve uniformity in related regulations.

NABPLAW Online Now Includes Guam, Puerto Rico, and the Virgin Islands

The complete pharmacy acts and regulations of Guam, Puerto Rico, and the Virgin Islands are now included in **NABP***LAW*® Online, the comprehensive national data bank of state pharmacy laws and regulations provided by NABP. **NABP***LAW* Online's powerful search capabilities allow users to research subjects one state at a time or across all 50 states and included jurisdictions. More information about **NABP***LAW* Online and a link to the online subscription order form are available in the Programs section of the NABP Web site at *www.nabp.net/programs/member-services/nabplaw/.*

Editor's Note: Pages two and three of this *Newsletter* are the 2013 *Third Quarter National Pharmacy Compliance News,* printed as a courtesy for your records. Pages four and five include the current 2013 *Fourth Quarter National Pharmacy Compliance News.* The *Arkansas State Board of Pharmacy Newsletter* continues on page six.

Enteric-Coated Aspirin Recalled for Potential Acetaminophen Mix-Up

In June 2013, Advance Pharmaceutical Inc initiated a voluntary recall of Rugby Laboratories label enteric-coated aspirin tablets, 81 mg (Lot 13A026; expiration date: January 2015) due to a complaint that a bottle labeled with this product name actually contained acetaminophen 500 mg tablets. This over-the-counter (OTC) product is packaged in bottles of 120 tablets with National Drug Code 0536-3086-41 and Universal Product Code 3 0536-3086-41 9. The affected lot was distributed nationwide by Rugby Laboratories to wholesalers and retailers. The manufacturer warns that inadvertently taking acetaminophen, 500 mg, instead of enteric coated aspirin, 81 mg, according to the directions on the label, can lead to an acetaminophen overdose and potential severe liver damage. The manufacturer indicates that consumers who take the dosage as indicated on the defective product labeling may be ingesting up to 24,000 mg of acetaminophen, which is about six times the maximum recommended daily dose of acetaminophen (4,000 mg).

Consumers who have bottles from the affected lot should stop using the product and return it to the pharmacy or store where it was purchased and should contact a health care provider if they are experiencing any problems that may be related to using the product. Food and Drug Administration (FDA) notes that any adverse reactions related to the use of the product should be reported to FDA's MedWatch Program. More information about this recall is available on the FDA Web site at *www.fda.gov/Safety/Recalls/ucm357909*.

Barcoding Technology for Community Pharmacy

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 an 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.*

Barcoding technology is well-established in industries outside of the health care sector and is now being used within health care to enhance efficiency and safety, and in pharmaceutical wholesale operations to improve supply chain inventory and efficiency. Numerous studies prove the effectiveness and cost benefits of using barcoding technology during the drug dispensing process. About 75% of wrong drug or wrong dose errors are captured and corrected using barcode technology[1] and there is sufficient evidence that barcode scanning is becoming the standard of practice in pharmacies.

Although barcoding technology is mature with abundant evidence regarding its effectiveness, a 2006[2] study showed that only half (53.5%) of United States community pharmacies utilize a barcode scanner for verification/identification of medications. The study also revealed significantly lower adoption in independent pharmacies (11.5%) compared to chain pharmacies (62.6%).

According to a survey conducted by ISMP in 2009, the most frequently reported reasons for implementing barcode scanning for product verification included a desire to improve the accuracy and safety of the dispensing process, the ease with which the technology fits with pharmacy workflow, improvement of staff efficiency and inventory control, and a belief that the technology was necessary to stay in business. The most common reasons for **not** implementing barcode scanning for product verification, other than cost, included uncertainty regarding the "right" vendor product, satisfaction with the current system (without barcode product verification), and perceptions that the technology would reduce staff efficiency.

ISMP has developed a tool, Assessing Barcode Verification System Readiness in Community Pharmacies, to help address the reasons why barcode scanning has not been implemented and to facilitate the adoption of this technology in an estimated 27,327 community pharmacies that do not currently utilize it for product verification.

Given the resource commitment to purchase barcoding systems and the potential for technology to have a profound effect upon the work environment, this tool will help community pharmacy managers and owners better understand the issues related to barcode product verification systems. It will also help managers assess the pharmacy's readiness for the technology, prepare for the selection of a system, and implement the technology effectively.

Barcode scanning to verify prescription products prior to dispensing improves the safety and quality of pharmacy care provided to patients and increases efficiency during the provision of pharmacy services. Although technology should not be seen as a panacea, it can be a useful tool when used appropriately and combined with other patient safety strategies.[3] Does your pharmacy use barcode technology for product verification? If not, please access this free tool, at *www.ismp.org/AHRQ/Default.asp?link=sa.*

[1]*Cochran GL, Jones KJ, Brockman J, Skinner A, et al. "Errors prevented by and associated with barcode medication systems." Joint Comm J Qual Pt Safety. 2007;33(5):293-301.*

Ukens C. "New study sheds light on medication errors." Drug Topics. 2002;146(21):33.

[2]*Skrepnek GH, Armstrong EP, Malone DC, Abarca J, et al. "Workload and availability of technology in metropolitan community pharmacies." J Amer Pham Assoc. 2006; 46(2):154-160.*

[3]*American Hospital Association, Health Research and Educational Trust, Institute for Safe Medication Practices. "Pathways for medication safety: assessing bedside bar-coding readiness." 2002. Accessed on October 15, 2010 at:* www.ismp.org/selfassessments/PathwaySection3.pdf.

ISMP Launches Medication Safety Alert! Newsletter Tailored for LTCFs

ISMP has launched a new *ISMP Medication Safety Alert!* publication, *Long-Term Care Advise-ERR,* as a means to provide medication error prevention information tailored to assist staff and providers in long-term care facilities (LTCFs).

With *ISMP Medication Safety Alert!* publications making a significant impact on preventing medication errors, ISMP is now providing this new resource tailored to LTCFs. ISMP notes that medication errors reported to ISMP Medication Errors Reporting Program include reports from LTCFs. More information and a link to subscribe to this new publication are available in the Newsletters section of the ISMP Web site at *www.ismp.org/newsletters/longtermcare.*

FDA Warns of Rare Skin Reactions in Patients Taking Acetaminophen

FDA has issued a consumer update that warns of rare but serious skin reactions that may occur in patients taking acetaminophen. These complications include three serious skin reactions: Stevens-Johnson Syndrome (SJS), toxic epidermal necrolysis (TEN), and acute generalized exanthematous pustulosis (AGEP). SJS and TEN can both be fatal, and usually require hospitalization. Patients suffering from AGEP commonly recover within a few weeks after they stop taking the medication that caused the reaction.

Symptoms of these conditions include skin rashes, blisters, and widespread damage to the surface of the skin. Patients taking acetaminophen or other compounds that contain acetaminophen should be advised to stop taking the medication if they experience such symptoms and should consult their health care providers or seek an emergency department immediately.

FDA emphasizes that this information should be viewed within the context of millions of patients who, over generations, have used and benefited from acetaminophen and stresses that severe allergic skin reactions are an extremely rare condition. Further, the agency notes that many medications can cause allergic reactions, and skin allergy warnings have already been added to the drug labels of other categories of OTC analgesics including ibuprofen and naproxen. "This new information is not intended to worry consumers or health care professionals, nor is it meant to encourage them to use other medications," said Sharon Hertz, MD, deputy director of FDA's Division of Anesthesia, Analgesia, and Addiction Products. "However, it is extremely important that people recognize and react quickly to the initial symptoms of these rare but serious side effects, which are potentially fatal." The full consumer update is available on the FDA Web site at *www.fda.gov/ForConsumers/ConsumerUpdates/ucm363010.htm.*

Reminder to Purchase Drugs Only from Licensed Wholesalers, Including VAWD-Accredited Wholesale Distributors

To ensure that patients are receiving safe, FDA-approved medications, pharmacists and other health care providers should purchase prescription drugs either directly from the manufacturer or from wholesale drug distributors licensed in the US as advised by FDA. The agency provides a list of state agencies for assistance in verifying licensure at *www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/ucm281446.htm*.

Another way that pharmacies can be assured of the legitimacy of a wholesale distributor is to look for the National Association of Boards of Pharmacy® (NABP®) Verified-Accredited Wholesale Distributors® (VAWD®) Seal. Those wholesale distributors that achieve VAWD accreditation are in compliance with state and federal laws and NABP's VAWD criteria. NABP has recently revised the VAWD criteria to allow virtual manufacturers and virtual wholesale distributors – a growing segment of the pharmaceutical wholesale industry – to qualify for VAWD, as well as to implement other changes aimed to help to ensure that the drug supply chain remains secure.

The revised VAWD criteria responds to changing business models and helps safeguard drugs in distribution at a time when there is an increased risk of counterfeit and substandard drugs entering the legitimate US drug supply chain. In particular, the criteria have been revised to provide stronger assurance that drugs diverted from pharmacies and unlawful sources are prevented from entering into the supply chain.

For a listing of VAWD-accredited facilities, please visit *www.nabp.net/programs/accreditation/vawd.*

Voluntary Recall of Unexpired Sterile Products After Reports of Adverse Events

FDA has announced a voluntary recall of all lots of unexpired sterile products produced by Specialty Compounding, LLC, in Cedar Park, TX. FDA received reports of 15 adverse events at two hospitals (Corpus Christi Medical Center Doctors Regional and Corpus Christi Medical Center Bay Area) potentially related to the use of these sterile products. Affected patients received an intravenous infusion of calcium gluconate supplied by the company.

Patients who were administered the injectable drug products are at risk of life-threatening infections. The recall applies to all unexpired sterile compounded medications dispensed by the company, including all strengths and dosage forms. Recalled products were distributed directly to hospitals and physicians' offices in Texas, and to patients located nationwide (with the exception of North Carolina). No calcium gluconate was shipped outside the state of Texas. Health care providers and patients should stop using all recalled products and return them to Specialty Compounding.

Veterinarians Not Eligible for NPIs, CMS Clarifies

Centers for Medicare and Medicaid Services (CMS) has become aware of cases in which veterinarians are told, incorrectly, that they must provide a National Provider Identifier (NPI) number for prescriptions they have written to be dispensed. The agency has issued a clarification, stressing that veterinarians do not meet the regulatory definition of "health care provider," and thus may not obtain NPI numbers. The clarification also states that "Any entity that insists veterinarians obtain an NPI [is] attempting to require veterinarians to obtain NPIs fraudulently." CMS also notes that "if a veterinarian fulfills the definition of 'health care provider' in a profession other than furnishing veterinary services," such as if they are also a nurse practitioner, "the veterinarian would be eligible for an NPI but would select a Nurse Practitioner code (not a Veterinarian code) from the Healthcare Provider Taxonomy Code Set when applying for an NPI."

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that has always been important in the prescription dispensing process but is much more transparent now with the PMP in place. In short, we do not need patient information linked to the wrong patients and we do not need prescriptions attributed to the wrong prescriber.

A secondary point is that pharmacists should not use fake or fictitious Drug Enforcement Administration (DEA) numbers when filling prescriptions for a prescriber. This may seem like an odd point but the Board has seen this practice in other states result in substantial fines from both DEA and the board of pharmacy for keeping and reporting inaccurate records to the PMP.

A final point of clarification is that the PMP is not held within the Board of Pharmacy and it is not managed by the Board of Pharmacy. Any questions about the program should be directed to the PMP administrator with the Arkansas Department of Health, Denise Robertson, PD, at denise .robertson@arkansas.gov or 501/683-3960.

Prescription Drug Take-Back and ARTakeBack.Org

The most recent nationwide, DEA-sponsored Prescription Drug Take-Back event occurred on October 26, 2013, and the Board had participation by law enforcement agencies across the state. Arkansas has become a national leader in these take-back events and surprised everyone involved with a total of 18,764 pounds of unused medications received during the April 2013 event, which surpassed its previous record by more than 50%. As a note, the Board partnered with the City of Benton Police Department, DEA, and State Drug Director Fran Flener on the *www.artakeback .org* Web site that has been and will continue to be updated with information surrounding drug disposal and destruction. The Board hopes that you will visit this site as well as promote it to your patients for their consideration in the storage and destruction of their prescription drugs.

License Renewals

Renewal notifications for pharmacists, in-state retail pharmacies, and out-of-state retail pharmacies were sent out in October. The Board sent reminder cards to show how to link to its Web site and renew your permit. These reminders were sent to your current mailing address on record with the Board office. If you need to change your mailing address on file with the Board, you must do so in writing (fax, mail, or e-mail) or by logging in to your licensure file through the Board Web site at *www.arkansas.gov/asbp*. As in years past, part of the renewal process will be for pharmacists to report their CE for the last two years. As a reminder, the CE requirements for the current biennium include a total of 30 hours of CE credit with 12 of the hours being live hours and 12 of the hours being Accreditation Council for Pharmacy Education (ACPE) accredited. Although your ACPE CE may be in the National Association of Boards of Pharmacy® CPE Monitor® system, you will still need to enter your CE into the Board renewal system. While this may seem redundant, the Board allows pharmacists to utilize non-ACPE-approved CE, so the Board will need to have 30 hours reported in its system in order to renew your pharmacist license. Furthermore, CPE Monitor is not directly linked to the Board's licensing software but can be used in part to verify CE reported to the Board. Specific questions regarding CE should be directed to Board staff. Only CE attained during the 2012-2013 biennium will count toward this requirement. Please remember that Board regulations require pharmacists to retain certificates of participation for proof of CE for a period of four years. As an important note, when renewing your pharmacist license, be sure to read and answer any questions correctly regarding any criminal issues to be reported to the Board as well as checking any applicable boxes to renew your immunization or preceptor certification. If you do not check these boxes on renewal, you will not have these endorsements noted on your license and will not be able to administer immunizations or serve as a preceptor for foreign pharmacy graduates as outlined in Board regulations.

Newsletter/Notification Changes

The Arkansas State Board of Pharmacy periodically sends out updates, *Newsletters,* current topics, and notifications by mail and/or e-mail. During the June 2012 meeting, the Board voted to phase out the mailing of these *Newsletters* in favor of sending electronic reminders of current issues as well as links to the quarterly *Newsletter* as posted on the Board Web site. As a part of this process, it is important to ensure that your contact information is current with the Board office, including your e-mail address as a point of contact.

If you would like to check your contact information, you may do so through the Board Web site by clicking on the License Maintenance link. Once you reach that screen, enter your license number, which includes PD as a designator for pharmacists and PT for technicians, followed by a five-digit number. If your license only has four numbers, then put a zero in front of those four digits such as PD01234 for the number 1234. Also, do not forget to update your information if you move or change jobs. Printed *Newsletters* ended after the May 2013 *Newsletter* and have switched to electronic format, which is available on the Board's Web site.

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

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