

TEMPORARY SUSPENSION ORDER #A-17-010-BS1

RE: IN THE MATTER OF
HOUSTON SOUTH SIDE PHARMACY
(PHARMACY LICENSE #25215)

BEFORE THE TEXAS STATE
BOARD OF PHARMACY

On this day came on to be considered by the Disciplinary Panel of the Texas State Board of Pharmacy (Board) the matter of the Petition for Temporary Suspension of pharmacy license number 25215, issued to Houston South Side Pharmacy (Respondent), 2626 South Loop, Suite 404, Houston, Texas 77054, pursuant to § 565.059 of the Texas Pharmacy Act (Pharmacy Act), TEX. OCC. CODE ANN., Title 3, Subtitle J.

Robert Charles Seals Jr., Individual Owner, on behalf of Respondent, and Don E. Lewis, Legal Counsel for Respondent, were in attendance. Caroline Hotchkiss represented Board staff. Kerstin Arnold served as General Counsel to the Disciplinary Panel. The following Board members served as the Disciplinary Panel: Jeanne D. Waggener, R.Ph.; Dennis F. Wiesner, R.Ph.; and Christopher M. Dembny, R.Ph.

The Disciplinary Panel determines that Respondent, by continuation in the operation of the pharmacy, would constitute a continuing threat to the public welfare, and that pharmacy license number 25215 issued to Respondent shall be temporarily suspended in accordance with § 565.059 of the Pharmacy Act. The Disciplinary Panel makes this finding based on the following evidence and/or information presented at the March 24, 2017, Hearing on Temporary Suspension of License of Respondent:

1. On or about August 29, 2006, Respondent, 2626 South Loop, Suite 404, Houston, Texas 77054, was issued Texas pharmacy license number 25215.
2. The individual owner of Respondent is Robert Charles Seals Jr.
3. As the holder of a pharmacy license, Respondent is liable for any violation of the Act by an employee of the pharmacy.

4. As the owner of a pharmacy, Mr. Seals has responsibility for all administrative and operational functions of the pharmacy.
5. A pharmacy is responsible for any violations in the practice of pharmacy by an owner or employee of the pharmacy.
6. The pharmacy license of Respondent was in full force and effect at all times and dates material and relevant to this Order.
7. The license of Respondent is current through January 31, 2018.
8. All jurisdictional requirements have been satisfied.
9. On or about August 11, 2010, the Board entered Agreed Board Order #B-09-023-B in the matter of Respondent. The Order was based on audit shortages of alprazolam 2mg tablets, hydrocodone/APAP 10/650 mg tablets, and promethazine with codeine syrup over a period of ten months, totaling 183,561 dosage units, and audit overages of hydrocodone/APAP 10/325 and 10/500 mg tablets, alprazolam 1mg tablets, and carisoprodol 350 mg tablets during the same ten month period as the shortages, totaling 474,945 dosage units. The Order imposed a two year probation and a \$10,000 penalty, and required the pharmacy to implement policies and procedures to prevent the loss of controlled substances.
10. Between on or about January 4, 2016, and December 7, 2016, Respondent and Frank A. Rollins, while acting as an employee (pharmacist-in-charge and a pharmacist), failed to comply with reporting requirements for dispensing of controlled substances to the State of Texas's applicable drug monitoring database, i.e. the Prescription Access Texas system (prior to September 1, 2016) and currently the Texas Prescription Monitoring Program (commencing September 1, 2016). Respondent and Mr. Rollins dispensed numerous prescriptions controlled substances between on or about January 4, 2016, and December 7, 2016, in that the pharmacy's drug audit trail of dispensing contains entries of dispensing 4,968 prescriptions for controlled substances (468,534 dosage units) during the above referenced time-period. However, according to data of the Texas Prescription Monitoring Program, the pharmacy reported dispensing of 0 prescriptions for controlled substances during this time-period.
11. Between on or about January 4, 2016, through December 7, 2016, which was during the time that Respondent and Frank A. Rollins failed to report to the drug monitoring database as described in Allegation (10), the pharmacy and Mr. Rollins, while acting as an employee (pharmacist-in-charge and a pharmacist), dispensed alprazolam 2mg tablets, hydrocodone/APAP 10/325 mg tablets, promethazine with codeine 6.25-10mg/5ml liquid, oxycodone 30 mg tablets, and carisoprodol 350 mg tablets, pursuant to prescriptions purportedly authorized by James Krause, M.D., or Phong Le, D.O., as follows:

Unauthorized Total Respondent Pharmacy:	2,753 RXs	266,112 Dosage Units
Unauthorized Total Rollins:	1,318 RXs	126,408 Dosage Units

Dr. Krause and Dr. Le did not authorize these prescriptions (the unauthorized prescriptions). Mr. Rollins should have known the unauthorized prescriptions were invalid, i.e. not issued for a legitimate therapeutic purpose or medical need and/or prescription forgeries, due to the following prescription red flags factors:

- a. The unauthorized prescriptions were for the above-listed controlled substances, which are popular as street drugs and have a high potential for abuse;
- b. The unauthorized prescriptions were for consistent large quantities of the above-listed controlled substances, e.g., 90 tablets of alprazolam 2mg, 120 tablets of carisoprodol 350 mg, 120 tablets of hydrocodone/APAP 10/325 mg, and 120 tablets of oxycodone 30 mg tablets;
- c. The unauthorized prescriptions were routinely dispensed to patients receiving more than one of the above-listed controlled substances on the same date;
- d. The unauthorized prescriptions routinely lack a specific diagnosis and the intended use for the drug prescribed;
- e. The unauthorized prescriptions were dispensed for patients outside the general area of the pharmacy, in that many patients purportedly travelled long geographic distances between Respondent and the residence listed on the prescriptions, which indicated patient addresses throughout Houston's metropolitan area and other Texas cities;
- f. The pharmacy purportedly sold the prescriptions in exchange for hundreds of dollars in cash;
- g. Patients receiving the unauthorized prescriptions were generally dispensed non-controlled drugs at the same time as the prescriptions for controlled substances, which were also purportedly authorized by Drs. Krause and Le, typically for multivitamins, antibiotics, pain relievers, and antacids, totaling 1,670 prescriptions;
- h. Over several months, the unauthorized prescriptions for the same or similar drugs, in the same or similar quantities, and in the same or similar combinations of drugs, were dispensed to multiple patients per day;
- i. The unauthorized prescriptions bear readily-identifiable markers of forgeries, including quantities, directions, spelling, or dosages differing from usual medical usage, prescriptions that do not comply with the acceptable standard abbreviations, prescriptions look "too good," i.e., patients names and addresses match exactly to driver's license or identification, and prescriptions are written in different color inks or written in different handwriting; and
- j. The unauthorized prescriptions were routinely presented to the pharmacy and Mr. Rollins, in that approximately almost half of all prescriptions dispensed by the pharmacy between January 4, 2016, and December 7, 2016, were the unauthorized prescriptions. Specifically, the pharmacy dispensed 4,968 total prescriptions for controlled substances during the above referenced time-period, of which approximately half of the total prescriptions were the

unauthorized prescriptions (2,753 RXs out of 4,968 RXs). In addition, during the same time period, the pharmacy also dispensed 743 prescriptions purportedly issued by Daniele Thomas, M.D., for the same controlled substances, i.e., alprazolam 2mg tablets, hydrocodone/APAP 10/325 mg tablets, promethazine with codeine 6.25-10mg/5ml liquid, oxycodone 30 mg tablets, and carisoprodol 350 mg tablets. These prescriptions purportedly issued by Dr. Thomas bear the same prescription red flags listed above in subparagraphs (a) through (i), and Mr. Rollins should have known that these prescriptions were also invalid.

12. Between on or about December 8, 2016, and January 2, 2017, Respondent and Frank A. Rollins, while acting as an employee (pharmacist-in-charge) operated the pharmacy on an infrequent basis, dispensing a total of 30 prescriptions during this approximately 30-day timeframe according to the pharmacy's drug audit trail of all dispensing, which shows that the pharmacy was not operating according to routine and regular pharmacy business. In addition, during this same time-period despite a lack of dispensing by the pharmacy, the pharmacy purchased approximately 30,000 tablets of hydrocodone/APAP 10/325 mg, oxycodone 30 mg, and alprazolam 2mg from drug wholesalers.
13. On or about January 3, 4, 5, and 6, 2017, Respondent and Frank A. Rollins, while acting as an employee (pharmacist-in-charge), failed to ensure the legal operation of the pharmacy, in that the pharmacy dispensed approximately 77 invalid prescriptions for the controlled substances, oxycodone 30 mg tablets and alprazolam 2mg tablets, purportedly issued by Parvez Qureshi, M.D. Prescriptions purportedly issued by Dr. Qureshi were the majority of prescriptions dispensed by the pharmacy in these four days according to the pharmacy's drug audit trail of all dispensing, i.e. 78% of the pharmacy's dispensing were prescriptions purportedly issued by Dr. Qureshi, and these prescriptions bear similar prescription red flags factors listed above in Allegation (11), which indicate that the prescriptions were invalid and not issued for a legitimate therapeutic purpose or medical need and/or prescription forgeries. Dr. Qureshi did not authorize the prescriptions.
14. On or after January 31, 2017, through on or about February 27, 2017, Respondent and Frank A. Rollins, while acting as an employee (pharmacist-in-charge) began reporting to the Prescription Drug Monitoring Program prescriptions dispensed on or after December 8, 2016. In this time period, the pharmacy and Mr. Rollins reported that the pharmacy has dispensed 122 prescriptions for controlled substances. The report demonstrates that the pharmacy and Mr. Rollins are continuing to operate not in accordance with routine and regular pharmacy business, and are continuing to engage in dispensing invalid prescriptions by dispensing high strengths of controlled substances, that are known to be routinely abused, in large quantities to patients travelling significant distances to receive the drugs from this pharmacy. Specifically, of these 122 prescriptions reported to the Prescription Drug Monitoring Program during this period, the pharmacy and Mr. Rollins have allowed the dispensing of 91 prescriptions (approximately 75% of the total reported prescriptions), consisting of the following:
 - 5 prescriptions each for 120 or 145 oxycodone 30 mg tablets (625 dosage units)

- for patients residing in Louisiana purportedly issued by James Key, M.D.,
- 38 prescriptions each for 60 alprazolam 2mg tablets (2,280 dosage units) purportedly issued by Parvez Qureshi, M.D., and
- 48 prescriptions purportedly issued by Azim Karim, M.D.
 - 27 prescriptions each for 120 oxycodone 30 mg tablets (3,240 dosage units),
 - 11 prescriptions each for 90 carisoprodol 350 mg tablets (990 dosage units), and
 - 10 prescriptions each for 114 hydrocodone/APAP 10/325 mg tablets (1,140 dosage units).

Subsequent to any proceedings involving the conduct described above, the Board may take additional disciplinary action on any criminal action taken by the criminal justice system based on the same conduct described in the allegations above. However, Respondent shall be provided all rights of due process should the Board initiate such disciplinary action subsequent to the conclusion of the criminal proceedings.

ORDER OF THE BOARD

THEREFORE, PREMISES CONSIDERED, the Board does hereby ORDER that:

- (1) Pharmacy license number 25215 held by Respondent shall be, and such license is hereby temporarily suspended. Said suspension shall be effective immediately and shall continue in effect, pending a contested case hearing on disciplinary action against the suspended license to be held at the State Office of Administrative Hearings not later than ninety (90) days after the date of this Order. During the period of suspension, Respondent shall:
 - (a) not operate as a pharmacy in this state in any manner that would allow receipt, distribution, or dispensing prescription drugs during the period said license is suspended; and
 - (b) remove the wall certificate for said license and any renewal certificate pertaining to said license from public display in a pharmacy and may not further display in public view said certificates.
- (2) Respondent shall immediately transfer all prescription drugs to a secured licensed pharmacy or other entity with the authority to legally possess prescription drugs, not later than March 31, 2017, and to immediately thereafter provide documentation of such transfer to the Board.

- (3) If Respondent does not immediately and fully comply with the terms of paragraph (2) above, the Board shall have the authority to remove all dangerous drugs from Respondent's establishment for the purpose of either transferring such drugs to a secured licensed pharmacy or other entity with the authority to legally possess dangerous drugs set forth in § 483.041(c) of the Texas Dangerous Drug Act, or destroying such drugs as in § 483.074 of the Texas Dangerous Drug Act.
- (4) Respondent shall be responsible for all costs relating to compliance with the requirements of this Order.
- (5) Failure to comply with any of the requirements in this Order constitutes a violation and shall be grounds for further disciplinary action. The requirements of this Order are subject to the Texas Pharmacy Act, TEX. OCC. CODE ANN., Title 3, Subtitle J (2015), and Texas Pharmacy Board Rules, 22 TEX. ADMIN. CODE (2017).

Passed and approved at the Temporary Suspension Hearing of the Disciplinary Panel of the Texas State Board of Pharmacy on the 24th day of March, 2017.

And it is so ORDERED.

THIS ORDER IS A PUBLIC RECORD.

SIGNED AND ENTERED ON THIS 24th day of March, 2017.


MEMBER, TEXAS STATE BOARD OF PHARMACY


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