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Group 1: **Limit sales of methamphetamine precursors**

Group Members: Etseygenet Assefa, Louisa Chu, Dennis Go, Marshall Heaster, Marcie Hume, Kristen Kai, Robert Lambert, Jill Mack

1. The manufacture and use of methamphetamine has escalated drastically using pseudoephedrine and ephedrine (P/E) as a major precursor. In order to control this problem, we are attempting to make the following changes:

**RCW 69.43.110**

*Ephedrine, pseudoephedrine, phenylpropanolamine -- Sales restrictions -- Penalty. (Effective January 1, 2006.)*

(1) It is unlawful for a pharmacy licensed by, or shopkeeper or itinerant vendor registered with, the department of health under chapter 18.64 RCW, or an employee thereof, or a practitioner as defined in RCW 18.64.011, knowingly to sell, transfer, or to otherwise furnish, in a single transaction:

(a) More than two packages of one or more products that he or she knows to contain ephedrine, pseudoephedrine, or phenylpropanolamine, their salts, isomers, or salts of isomers; or

(b) A single package of any product that he or she knows to contain more than three 1.2 grams of ephedrine, pseudoephedrine, or phenylpropanolamine, their salts, isomers, or salts of isomers, or a combination of any of these substances.

(2) It is unlawful for a person who is not a manufacturer, wholesaler, pharmacy, practitioner, shopkeeper, or itinerant vendor licensed by or registered with the department of health under chapter 18.64 RCW to purchase or acquire, in any twenty-four hour period, more than the quantities of the substances specified in subsection (1) of this section, further, no pharmacist or pharmacy shall sell to any person, nor shall any person obtain more than twice the maximum quantity set for the in (1)(a) and (1)(b) above.
in any 60 day period.

(3) It is unlawful for any person to sell or distribute any of the substances specified in subsection (1) of this section unless the person is licensed by or registered with the department of health under chapter 18.64 RCW, or is a practitioner as defined in RCW 18.64.011.

(4) A violation of this section is a gross misdemeanor.

Section 1(b) of RCW 69.43.110 is amended by striking “three grams” and inserting “1.2 grams”. Section 2 of RCW 69.43.110 is amended by adding after “of this section” “further, no pharmacist or pharmacy shall sell to any person, nor shall any person obtain more than twice the maximum quantity set forth in (1)(a) and (1)(b) above in any 60 day period”.

**Group 1: Limit sales of methamphetamine precursors**

Group Members: Etsegnet Assefa, Louisa Chu, Dennis Go, Marshall Heaster, Marcie Hume, Kristen Kai, Robert Lambert, Jill Mack

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Three potential alternatives to our proposed legislation (to restrict sales to two packages of no more than 1.2g of pseudoephedrine, and no more than two purchases per 60 day period) are: 1) to make pseudoephedrine a prescription only medication, 2) to pull the tablet form of pseudoephedrine from the market, 3) leave the current legislation as it is.

1) The best alternative of the three, in terms of viability and operability would be to take a "wait and see" approach. The feasibility of how the most recent changes to restrictions on pseudoephedrine sales in Washington will affect diversion of goods to the production of methamphetamine, has yet to be determined, but will be seen over time through a decrease in seized methamphetamine and methamphetamine labs, as well as a decrease in methamphetamine related crimes.

2) Our proposed legislation and alternative number 3 have superior political viability and administrative operability to the first two alternatives. The technical feasibility for all three is difficult to determine as it is dependent on many factors unrelated to restriction in sales.

3) It may be difficult to gain a lot of political support for changing pseudoephedrine to a prescription only medication and WSMA would not support such legislation as it adds more to the burden of the prescriber with no real benefit passed on to the patients. Manufactures, who have a lot of political pull, would not support the recall of pseudoephedrine tablets, especially since methamphetamine makers may then just switch to liquid formulations to obtain methamphetamine precursors. All forms of pseudoephedrine would need to be removed from market to stop that from occurring, but patients would not want to give up such a good decongestant, especially when there are few viable OTC alternatives.

**Group #2: Prescription Only Pseudoephedrine**

Elyse Tung, Leigh Brown, Angela Hitt, Vu Hoang, Jared Judd, Young Mi Kim, Karyn
Changes mainly in chapter 69.43 of the RCW:

New Section under RCW 69.43:

**RCW 69.43.XX**

**Ephedrine, pseudoephedrine, phenylpropanolamine – Legend drug status.**

(1) It is unlawful to possess, sell, transfer or furnish any product containing ephedrine, pseudoephedrine, or phenylpropanolamine, their salts, isomers, or salts of isomers, or a combination of any of those substances unless the product was obtained directly from, or pursuant to, a valid prescription or order of a practitioner while acting in the course of a professional practice as defined in 69.41, RCW.

(2) The board of pharmacy, by rule, may exempt products containing ephedrine, pseudoephedrine, or phenylpropanolamine, or their salts, isomers, or salts of isomers, in combination with another active ingredient from the requirements of this section if they are found not to be used in the illegal manufacture of methamphetamine or other controlled dangerous substances. A manufacturer of a drug product may apply for removal of the product from the requirements of this section if the product is determined by the board to have been formulated in such a way as to effectively prevent the conversion of the active ingredient into methamphetamine. The burden of proof for exemption is upon the person requesting the exemption. The petitioner shall provide the board with evidence that the product has been formulated in such a way as to serve as an effective general deterrent to the conversion of pseudoephedrine into methamphetamine. The evidence must include the furnishing of a valid scientific study, conducted by an independent, professional laboratory and evincing professional quality chemical analysis. Factors to be considered in whether a product should be excluded from this section include but are not limited to:

   (a) Ease with which the product can be converted to methamphetamine;
   
   (b) Ease with which ephedrine, pseudoephedrine, or phenylpropanolamine is extracted from the substance and whether it forms an emulsion, salt, or other form;
   
   (c) Whether the product contains a "molecular lock" that renders it incapable of being converted into methamphetamine;
   
   (d) Presence of other ingredients that render the product less likely to be used in the manufacture of methamphetamine; and
   
   (e) Any pertinent data that can be used to determine the risk of the substance being used in the illegal manufacture of methamphetamine or any other controlled substance.

(3) Nothing in this section applies:

   a. To any product containing ephedrine, pseudoephedrine, or phenylpropanolamine, or their salts, isomers, or salts of isomers that is not the only active ingredient and that is in liquid, liquid capsule, or gel capsule form:
Changes/deletions:

**RCW 69.43.030**

Exemptions.

RCW 69.43.010 and 69.43.020 do not apply to any of the following:

1. Any pharmacist or other authorized person who sells or furnishes a substance upon the prescription of a practitioner, as defined in chapter 69.41, RCW;
2. Any practitioner who administers or furnishes a substance to his or her patients;
3. Any manufacturer or wholesaler licensed by the state board of pharmacy who sells, transfers, or otherwise furnishes a substance to a licensed pharmacy or practitioner;
4. Any sale, transfer, furnishing, or receipt of any drug that contains ephedrine, phenylpropanolamine, or pseudoephedrine, or of any cosmetic that contains a substance specified in RCW 69.43.010(1), if such drug or cosmetic is lawfully sold, transferred, or furnished, over the counter without a prescription under chapter 69.04 or 69.41, RCW.

*Note: This changes the exemption that PE can be sold OTC, even though it is listed as a precursor drug.*

The existing sales regulations under the following RCW sections would no longer be necessary, but some of the language was adopted:

- 69.43.105 Ephedrine, pseudoephedrine, phenylpropanolamine -- Sales restrictions -- Exceptions -- Penalty
- 69.43.110 Ephedrine, pseudoephedrine, phenylpropanolamine -- Sales restrictions -- Penalty

**RCW 69.43.120**

Ephedrine, pseudoephedrine, phenylpropanolamine -- Possession of more than fifteen grams -- Penalty -- Exceptions.

1. Any person who possesses more than fifteen grams of ephedrine, pseudoephedrine, or phenylpropanolamine, their salts, isomers, or salts of isomers, or a combination of any of those substances, is guilty of a gross misdemeanor.
2. This section does not apply to any of the following:
   a. A pharmacist or other authorized person who sells or furnishes ephedrine, pseudoephedrine, or phenylpropanolamine, their salts, isomers, or salts of isomers upon the prescription of a practitioner, as defined in RCW 69.41.010;
   b. A practitioner who administers or furnishes ephedrine, pseudoephedrine, or phenylpropanolamine, their salts, isomers, or salts of isomers to his or her patients;
(c) A pharmacy, manufacturer, or wholesaler licensed by, or shopkeeper or itinerant vendor registered with, the department of health under chapter 18.64, RCW;

(d) A person in the course of his or her business of selling, transporting, or storing ephedrine, pseudoephedrine, or phenylpropanolamine, their salts, isomers, or salts of isomers, for a person described in (a), (b), or (c) of this subsection; or

(e) A person in possession of more than fifteen grams of ephedrine, pseudoephedrine, or phenylpropanolamine, their salts, isomers, or salts of isomers in their home or residence under circumstances consistent with typical medicinal or household use as indicated by, but not limited to, storage location and possession of products in a variety of strengths, brands, types, purposes, and expiration dates.

*This is an example of a deletion pertaining to the valid OTC PE sales via registration with the DoH. Other similar deletions may exist.

Reference.

Oregon House Bill HB 2485.
http://landru.leg.state.or.us/05reg/measpdf/hb2400.dir/hb2485.en.pdf

**Group 2: Prescription Only Pseudoephedrine**

Leigh Brown, Shawn Hancey, Angela Hitt, Vu Hoang, Jared Judd, Young Mi Kim, Karyn Moretsky, Elyse Tung

**Chosen alternative: Pseudoephedrine as a legend drug**

Making pseudoephedrine a legend drug has the potential to increase healthcare costs. It also limits access to those uninsured individuals who would have to pay for an office visit just to treat the symptoms of a common cold. People, insurance companies, and Medicaid will have to spend money for a physician visit that was previously avoided by self-treatment with OTC pseudoephedrine products.

Much of this cost might be mitigated by refill authorizations if the physician trusts that the patient is using the product for treatment of congestion. For uninsured patients, access to public health clinics or pharmacists with pseudoephedrine prescriptive protocols could be helpful in reducing the access burden.

**Alternative 1: Scheduling (Schedule V) Pseudoephedrine**

1. **Worst possible**: The legislation has no effect on the amount of methamphetamine production or abuse in Washington, but people who legitimately need pseudoephedrine are bothered by the hassle and expense of seeing a doctor (even more often than with an unscheduled legend drug) for conditions they feel are self-treatable.

   **Best possible**: Methamphetamine labs, production, and abuse are greatly decreased, reducing drug-related crime and pollution in the state. Patients are inconvenienced, but still receive the pharmacological care they need.

   **“Get real”**: The number of methamphetamine labs in the state is slightly reduced.
Importation may increase to replace the amount of drug lost, and the amount of abuse will likely stay the same.

2. Make Pseudoephedrine a schedule V legend (rx only) drug. Since the goal of this action would be to reduce the amount of methamphetamine manufactured and overall methamphetamine use, the measure of success could be determined by a reduction of methamphetamine related crime—specifically the number of meth labs seized and the number of people found in possession of methamphetamine. Currently we don’t have a realistic numerical estimate of how much these methamphetamine crimes would be reduced if pseudoephedrine products (excluding liquid formulations) went to prescription only. We could estimate that the reduction in meth labs seizures (an indicator of decreased meth production) would be greater than 50%, which is the approximate reduction seen in Oklahoma after the made pseudoephedrine a schedule V controlled substance (with exceptions.) Since the making pseudoephedrine rx only would provide even tighter control on the substance, it is a reasonable assumption that Washington’s reduction would be significantly greater than Oklahoma’s should they implement this law.

3. Scheduling pseudoephedrine would place an increased regulatory burden on pharmacies. There are no feasible ways to mitigate this impact, as a product either falls under a schedule and must be treated as a scheduled substance or it does not.

**Alternative 2: Maintain status quo law until federal legislation is passed**

1. **Worst possible:** Federal legislation takes an extremely long time to be enacted, and the state’s methamphetamine problem becomes much worse in the meantime (including the violent crime, child neglect/abuse, theft, and pollution associated with it).

2. **Best possible:** Federal legislation is enacted quickly, and completely takes care of Washington’s methamphetamine problem. Labs, importation, abuse, and related crime are all greatly reduced.

3. **“Get real”**: Federal law will take some time to have an effect. The state’s problem will grow gradually worse in the meantime, and then be somewhat reduced, remaining a major issue.

2. Keep the current law in place and wait for federal legislation on the subject to solve the problem. Last year in Washington there were 947 meth lab incidents. While the number of meth labs found fluctuates from year to year, there is no indication that an effective reduction in meth production will occur without cutting it off at the source, specifically pseudoephedrine. In the time spent waiting for the federal government to act more will be falling apart due to methamphetamine use. In 2001, 5,700 people were admitted to publicly funded treatment centers for treatment of meth addiction. We cannot afford to wait.

3. The status quo places an increased burden on already busy pharmacies. This is not part of their regular workflow and will take increased staff time. Pharmacies could lessen this impact by using pharmacy assistants to complete the logging procedures.

Waiting until federal legislation is passed still allows methamphetamine producers to have more access to pseudoephedrine products than in Oregon, potentially bringing them to our state while we wait for federal legislation.

**Alternative 3: Create a third class of drugs**
1. **Worst possible**: The plan is implemented with a great degree of variation or not at all in many pharmacies. It has no effect on methamphetamine production, and stops legitimate patients from getting the medications they need.

**Best possible**: All pharmacies fully implement the plan. Pharmacists accurately determine those purchasing pseudoephedrine for the purpose of making methamphetamine and refuse to sell it to them. Methamphetamine production in the state is significantly reduced.

**“Get real”**: The plan is implemented with some degree of variation from pharmacy to pharmacy. Although it is more difficult, many people producing meth are still able to purchase the pseudoephedrine they need in pharmacies. Methamphetamine production is only slightly reduced.

2. Washington State has decided to make pseudoephedrine a special substance in its own category. They will require signatures and photo identification for the purchase of pseudoephedrine containing products, and have placed quantity restrictions on purchase and possession. This has proven to be effective in reducing methamphetamine productions (as measured by a decrease in lab seizures) in Oklahoma, which is the best state to obtain statistics on the effectiveness of the law, since they were the first to implement similar measures. They saw an immediate reduction from in the total number of meth lab seizures from 1,197 seizures in 2003, to 584 in 2004, and the law didn’t even go into place until April of 2004. This represents around a 50% reduction in methamphetamine production. Washington State should expect similar results after implementing their new law in January.

3. In the current system, a third class of drugs could be a drain on pharmacy staffing resources, at least until pharmacists are more readily paid for their services by insurance companies/patients. This problem could potentially correct itself as the value of pharmacy services becomes more apparent to insurance companies with the profession’s involvement in MTMS of Medicare Part D.

**Group 3 – Show and Tell**
Joe Johnson, Helen Song, Connor Christy, Olga Shvartsur, Zachary Beard, Aaron Chin, Lydia Zou, Tina Ngo

**WAC 246-869-220 Patient counseling required.** The purpose of this counseling requirement is to educate the public in the use of drugs and devices dispensed upon a prescription.

(1) The pharmacist shall directly counsel the patient or patient's agent on the use of drugs or devices.

(2) For prescriptions delivered outside of the pharmacy, the pharmacist shall offer in writing, to provide direct counseling and information about the drug, including information on how to contact the pharmacist.

(3) For each patient, the pharmacist shall determine the amount of counseling that is reasonable and necessary under the circumstance to promote safe and effective administration of the medication and to facilitate an appropriate therapeutic outcome for that patient from the prescription. **The pharmacist shall present all new medication(s) and previous medication(s) that have changed strength, brand, or dosage form individually to**
the patient for a visual inspection upon dispensing of said medication(s), with the exception that a patient may opt to forgo such inspection at his/her own risk.

(4) This rule applies to all prescriptions except where a medication is to be administered by a licensed health professional authorized to administer medications.

**Group 3 (show and tell group) Project outcomes**

Joe Johnson, Helen Song, Connor Christy, Olga Shvartsur, Zachary Beard, Aaron Chin, Lydia Zou, Tina Ngo

1) **Make exception for mail-order pharmacies for alternative “showing” methods such as description of medication and/or picture of medication on the bottles.**
   - Patients will not pay attention to all of the paperwork coming through the mail, increasing their risk of not noticing a wrong medication. Furthermore, increasing the paperwork on the mail order end may just cause more confusion for them and the wrong drug picture may be incorporated if they do not get around to updating the pictures.

2) **Exempt mail-order pharmacies or any prescriptions filled from pharmacies that provide mail-order services.**
   - Mail order companies will have an unfair advantage over ambulatory pharmacies in that their dispensing costs and efforts will be even lower.

3) **Allow pharmacies to choose their preferred method of “showing” as they deem appropriate. This can include the description of medication and/or picture of medication on the bottles.**
   - Preferred method of showing will most likely be the one that requires the least amount of effort (i.e., less effort = less time spent with patient).

Alternatives 1 and 3 are comparable in terms of their ability to reduce medication errors. Alternative 2, however, does nothing to alter the current mail order situation. While we hope that all pharmacies will choose to increase the amount of time spent counseling patients regarding medication identification for their disease state management (best case scenario), we realize that financial and staffing constraints may not allow this. No matter which alternative is chosen, though, it is still better than having nothing in place; any verification method is better than nothing. Realistically, the effects will vary between pharmacies depending on how committed they are to patient contact.

**Group 4 Expiration of Schedule II Prescriptions**

Group Members: Quyen Nguyen, Mai Linh, Andrea Eberly, Jeff Loor, Goeff Meer, Jennifer Law, Nick Wyatt, Sareh Ghazanfarpour

**RCW 69.50.308 Prescriptions**

c. In emergency situations, as defined by rule of the state board of pharmacy, a substance included in Schedule II may be dispensed upon oral prescription of a practitioner, reduced to promptly to writing and filed by the pharmacy. Prescription shall be retained in conformity with the requirements of RCW 69.50.306. **A prescription for a substance included in Schedule II may not be refilled.**
not be filled or refilled more than 90 days after the date thereof or be refilled more than two times for a maximum of 90 days supply.

Group 5 “Black Box Warning” for the Benzodiazepines
Group Members: Osama Saleh, Carolyn Sear, Kevin Hiroo, Rachel Nowak, Hae Young Zhang, Vivian Villanueva, Benjamin Davis, BJ Gleason

As our current purpose is to implement a "Black Box Warning" for the entire Benzodiazepine class, we are not really changing or adding to the existing legislation governing this issue.

Group 6
Our group is modifying the law RCW 69.41.050 which is the Labeling requirements and states the following:
To every box, bottle jar, tube or other container of a legend drug, which is dispensed by a practitioner authorized to prescribe legend drugs, there shall be affixed a label bearing the name of the prescriber, complete directions for use, the name of the drug either by the brand or generic name and strength per unit dose, indicated use of the drug, name of patient and date: PROVIDED, That the practitioner may omit the name and dosage of the drug if he determines that his patient should not have this information and that, if the drug dispensed is a trial sample in its original package and which is labeled in accordance with deferral law or regulation, there need be set forth additionally only the name of the issuing practitioner and the name of the patient.

Group 7 Label Requirements - Description and Picture
Madeline Lorraine Fry, Caroline Kim, Casey D Lirot, Suejin Park, Catherine De La Cruz Ulep, Dimay Wang, Caroline Yuan-Chi Wu, Chris B. Yocom

WAC 246-869-210 Prescription labeling. To every prescription container, there shall be fixed a label or labels bearing the following information:
(1) All information as required by RCW "/rcw/index.cfm?fuseaction=section&section=18.64.246", provided that in determining an appropriate period of time for which a prescription drug may be retained by a patient after its dispensing, the dispenser shall take the following factors into account:, ect........
(2) The quantity of drug dispensed, for example the volume or number of dosage units.
(3) The following statement, "Warning: State or federal law prohibits transfer of this drug to any person other than the person for whom it was prescribed."
(4) A black and white pictorial and written description of dispensed drug containing shape, color, and imprints of side one and side two.
(5) The information contained on the label shall be supplemented by oral or written information as required by WAC "http://www.leg.wa.gov/wac/index.cfm?fuseaction=section&section=246-869-220".

Comment [13]: Won't this put you in conflict with federal law?: 21CFR Sec. 1306.12 Refilling prescriptions.
The refilling of a prescription for a controlled substance listed in Schedule II is prohibited.
1. We are changing the WAC 246-869-210 Prescription Labeling

**Group 9 Rescheduling of Tramadol**
Group Members: Holly Dirks, Michael King, Amy Little, Adam McCown, Pavel Mitin, Robert Siegfried, Gigi Wong

We plan on adding “tramadol” to the list of Schedule IV substances in the WAC 246-887-170. It would be modified as follows:

**WAC 246-887-170 Schedule IV.** The board finds that the following substances have a low potential for abuse relative to substances in Schedule III and have currently accepted medical use in treatment in the United States and that the abuse of the substances may lead to limited physical dependence or psychological dependence relative to the substances in Schedule III. The board, therefore, places each of the following substances in Schedule IV.

(a) The drugs and other substances listed in this section, by whatever official name, common or usual name, chemical name, or brand name designated, are included in Schedule IV.

[...]  

(f) Other substances. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including its salts:

(1) Pentazocine;  
(2) Butorphanol;  
(3) Tramadol.

**Group 10 Generic Substitution**
Jasmine Chase, Frances McGaugh, Michael Fallon, Thu Dang, Melvin Wang, Ching Chow, Whitney Stoffel.

**RCW 69.41.120 Prescriptions to contain instruction as to whether or not a therapeutically equivalent generic brand name drug may must be substituted dispensed—Out-of-state prescriptions—Form—Contents—Procedure.** Every drug prescription shall contain an instruction on whether or not a therapeutically equivalent generic drug may be substituted in its place, unless substitution is permitted under a prior consent authorization. If a written prescription is involved, the prescription must be legible and the form shall have two signature lines at opposite ends on the bottom of the form. Under the line at the right side shall be clearly printed the words “DISPENSE AS WRITTEN”. Under the line at the left side shall be clearly printed the words “SUBSTITUTION PERMITTED”. The practitioner shall communicate the instructions to the pharmacist by signing the appropriate
No prescription shall be valid without the signature of the practitioner on one of these lines. If a written prescription is involved, the prescription must be legible and the form shall have one line for signature. No prescription shall be valid without the signature of the practitioner. In the case of a prescription issued by a practitioner in this state or another state that uses a one-line prescription form or variation thereof, the pharmacist may substitute a therapeutically equivalent generic drug unless otherwise instructed by the practitioner through the use of the words “dispense as written”, words of similar meaning, or some other indication. At any time, if patient prefers brand, brand may be dispensed. If the prescription is from a state that uses a two line system, the pharmacist shall follow the instructions indicated by the signature line (dispense as written or substitution allowed).

If an oral prescription is involved, the practitioner or the practitioner’s agent shall instruct the pharmacist as to whether or not a therapeutically equivalent generic drug may be substituted in its place they request brand by stating “dispense brand only” or words of similar effect. The pharmacist shall note the instructions on the file copy of the prescription.

The pharmacist shall note the manufacturer of the drug dispensed on the file copy of a written or oral prescription.

Best Alternative

The best alternative to the current law would be to make generic substitution mandatory when available, unless the prescriber states otherwise or the patient chooses brand. This would make the prescription pad one line only for the prescriber to sign. There will be no change to the lack of liability of the pharmacist, as there is not a therapeutic substitution occurring, only a brand to generic substitution.

This change is superior to the other alternatives because it does not remove the prescriber’s choice of brand or generic, so there shouldn’t be much resistance from that front. Also, it will save time and money by decreasing the communication needed between prescriber and pharmacist to use generic when it becomes available. This alternative is relatively easy to implement from an administrative or technical viewpoint, and would have the backing of several groups (politically), to include patient advocacy and insurance groups.

Allowing the pharmacist to make a therapeutic interchange either through consultation of the orange book, or by use of a table of unacceptable interchanges, would be difficult to implement. There would be a lot of opposition from prescribers who would feel their power was being removed, from brand name manufacturers who would want their drug on the list to not substitute, and it would be hard to come up with a list and keep it updated fairly. The change in law regarding a pharmacist’s liability would also have to change and may meet resistance from pharmacists and drugstore owners themselves.

Group 11: Ensuring the Quality of Internship Experience

Amy Thomas, Stacie Chen, Kelly Philopant, Chris Rogge, Julie Sun, Rebecca Goodwin, Tuyen Huynh

Alternative #1: Providing CE credits to preceptors for positive internship evaluations

“Worst possible”: Giving preceptors CE credits for positive biannual reports submitted by interns will reduce the amount of CE credits the preceptor could be getting from more informative CE information (e.g. drug information, disease states, etc.)

“Best possible”: By providing CE credits this will provide incentive for the preceptor to provide a more quality internship experience.
“Get real”: This alternative most likely will never be implemented because it is a frivolous way of providing CE credits.

Therefore, this alternative will not be part of our recommendation.

Alternative #2: Establish guidelines for preceptors to follow in order to provide a quality internship experience.

“Worst possible”: The guidelines may be inferior to already established guidelines such as ACPE standards for introductory internships.
“Get real”: Realistically, we want to give the BOP the power to establish their own guidelines rather than creating guidelines for them to use.

Some undesirable side-effect is that the BOP may establish vague guidelines which will provide no change to the quality internship experiences.

Alternative #3: Internship evaluations will be mandatory in order to renew intern licenses. This can be done online.

"Worst possible": It may be inefficient and some students will not be employed when they have to renew their internship licenses. Therefore, the evaluations will not be applicable.
"Best possible": There will be timely feedback at regular intervals. In addition, this will be more enforceable because licenses will not be renewed if an evaluation is not submitted.
"Get real": This is a realistic option. It is a logical time to complete evaluations since interns would need to renew their licenses annually.

This will ensure around 100% submission of evaluations since interns would need to renew their licenses. A certain side-effect is that someone would need to create an online response system which may be time consuming and costly.

**Group 12 - Partial Fills of C-II Prescriptions**

Group Members: Ashley Bean, Amy Chang, Morgan Hutchings, Rachel Schreffler, Kathleen Thornton, Kelli Watari, Jeff White

1. Existing Regulation:

§1306.13 Partial filling of prescriptions

(a) The partial filling of a prescription for a controlled substance listed in Schedule II is permissible, if the pharmacist is unable to supply the full quantity called for in a written or emergency oral prescription and he makes a notation of the quantity supplied on the face of the written prescription (or written record of the emergency oral prescription). The remaining portion of the prescription may be filled within 72 hours of the first partial filling; however, if the remaining portion is not or cannot be filled within the 72 hour period, the pharmacist shall so notify the prescribing individual practitioner. No further quantity may be supplied beyond 72 hours without a new prescription.

2. Proposed Regulation:

§1306.13 Partial filling of prescriptions

Comment [15]: yes, but you can save them time by providing a draft

Comment [16]: the correct punctuation is strike through the stuff you are eliminating and underline the new stuff, all in the same sentence, etc.
(a) The partial filling of a prescription for a controlled substance listed in Schedule II is permissible, if the pharmacist is unable to supply the full quantity called for in a written or emergency oral prescription and he or she makes a notation of the quantity supplied on the face of the written prescription (or written record of the emergency oral prescription). The remaining portion of the prescription must be completed in full within seven days. If the remaining portion is not or cannot be filled within the seven day period, the pharmacist shall so notify the prescribing individual practitioner. No further quantity may be supplied beyond seven days without a new prescription and each prescription may only be partially filled once.