

BEFORE THE IOWA BOARD OF PHARMACY

Re:)	Case No. 2012-48 & 2012-57
Pharmacist License)	
PATRICIA RANDEL)	STATEMENT OF CHARGES
License No. 18060,)	& NOTICE OF HEARING
Respondent.)	

COMES NOW the Iowa Board of Pharmacy (Board) and files this Notice of Hearing and Statement of Charges pursuant to Iowa Code sections 17A.12(2) and 17A.18(3). Respondent was issued Iowa pharmacist license number 18060. Respondent's license is currently active.

A. TIME, PLACE, AND NATURE OF HEARING

Hearing. A disciplinary contested case hearing shall be held on April 23, 2013, before the Iowa Board of Pharmacy. The hearing shall be held during the morning session, beginning at 9:00 a.m. and shall be located in the Board conference room located at 400 S.W. 8th Street, Des Moines, Iowa.

Presiding Officer. The Board shall serve as presiding officer, but the Board may request an Administrative Law Judge from the Department of Inspections and Appeals make initial rulings on prehearing matters, and be present to assist and advise the board at hearing.

Hearing Procedures. The procedural rules governing the conduct of the hearing are found at 657 Iowa Administrative Code rule 35.19. At hearing you will be allowed the opportunity to respond to the charges against you, to produce evidence on your behalf, cross-examine witnesses, and examine any documents introduced at hearing. You may appear personally or be represented by counsel at your own expense. The hearing may be open to the public or closed to the public at your discretion.

Prosecution. The office of the Attorney General is responsible for representing the public interest (the State) in this proceeding. Pleadings shall be filed with the Board and copies should be provided to counsel for the State at the following address.

Meghan Gavin
Assistant Attorney General
Iowa Attorney General's Office
2nd Floor Hoover State Office Building
Des Moines, Iowa 50319.

Ms. Gavin can also be reached by phone at (515)281-6736 or e-mail at Meghan.Gavin@iowa.gov.

Communications. You may contact the Board office (515)281-5944 with questions regarding this notice and other matters relating to these disciplinary proceedings. However, you may NOT contact individual members of the Board to discuss these proceedings by phone, letter, facsimile, email, or in person. Board members can only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings you file with the Board office and serve upon all parties in the case. You may also direct questions relating to settlement of these proceedings to Assistance Attorney General Meghan Gavin at (515)281-6736.

B. LEGAL AUTHORITY AND JURISDICTION

Jurisdiction. The Board has jurisdiction in this matter pursuant to Iowa Code chapters 17A, 147, 155A, and 272C (2011).

Legal Authority. If any of the allegations against you are founded, the Board has authority to take disciplinary action against you under Iowa Code chapters 17A, 147, 148C, and 272C (2011) and 657 Iowa Administrative Code chapter 36.

Default. If you fail to appear at the hearing, the Board may enter a default decision or proceed with the hearing and render a decision in your absence, in accordance with Iowa Code section 17A.12(3) and 657 Iowa Administrative Code rule 35.21.

C. CHARGES

Count I

VIOLATING THE DUTIES OF A PHARMACIST-IN-CHARGE

Respondent is charged with violating her duties as a pharmacist-in-charge in violation of Iowa Code section 155A.12(1) and 657 Iowa Administrative Code rules 6.2(1) and (9) and 36.1(4)(u).

Count II

FAILURE TO VERIFY A CONTROLLED SUBSTANCE PRESCRIPTION

Respondent is charged with failing to properly verify a controlled substance prescription in violation of Iowa Code section 155A.12(1) and 657 Iowa Administrative Code rules 10.21(2) and 36.1(4)(u).

D. FACTUAL CIRCUMSTANCES

1. Respondent holds Iowa pharmacist license #18060. At all times material to the charges, Respondent was the pharmacist-in-charge at Medicap Pharmacy at 615 East Main Street, Panora, Iowa 50216.

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2. On October 12, 2011, patient Ronald Benedict was prescribed two Schedule II medications by Dr. Mark Witkowski at Mercy Hospital. Both prescriptions were filled by the Respondent that same day.

3. The Respondent's pharmacy processed the prescriptions using the name of Dr. Denville Myrie as the prescriber.

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4. On at least two occasions, the Respondent's pharmacy misfiled prescriptions for patient Patricia Holbrook.

5. These misfills were not recorded in Respondent's CQI program.

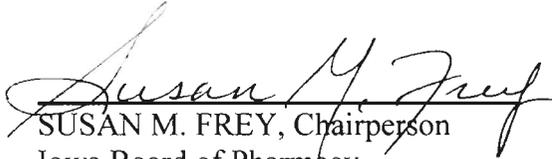
6. Two of the three pharmacy technicians at Respondent's pharmacy had not been trained on the CQI program.

E. SETTLEMENT

This matter may be resolved by settlement agreement. The procedural rules governing the Board's settlement process are found at 657 Iowa Administrative Code rule 36.3. If you are interested in pursuing settlement of this matter, please contact Assistant Attorney General Meghan Gavin.

F. PROBABLE CAUSE FINDING

On this 13th day of March, 2013, the Iowa Board of Pharmacy found probable cause to file this Notice of Hearing and Statement of Charges.


SUSAN M. FREY, Chairperson
Iowa Board of Pharmacy
400 SW Eighth Street, Suite E
Des Moines, Iowa 50309-4688

cc: Meghan Gavin
Assistant Attorney General
Hoover State Office Building
Des Moines, Iowa

PROOF OF SERVICE

The undersigned certifies that the foregoing instrument was served upon Respondent to the above cause by:

- | | |
|--|---|
| <input type="checkbox"/> personal service | <input type="checkbox"/> first class mail |
| <input checked="" type="checkbox"/> certified mail, return receipt requested | <input type="checkbox"/> facsimile |
| Article Number 9171999991703106849770 | <input type="checkbox"/> other _____ |

on the 14th day of March, 2013.

I declare that the statements above are true to the best of my information, knowledge and belief.


Debbie S. Jorgenson

BEFORE THE IOWA BOARD OF PHARMACY

IN THE MATTER OF:)	CASE NO: 2012-48 & 2012-57
)	DIA NOS. 13PHB023
Pharmacy License of)	
MEDICAP PHARMACY)	
License No. 189)	
)	FINDINGS OF FACT,
Pharmacist License of)	CONCLUSIONS OF LAW,
PATRICIA RANDEL,)	DECISION AND ORDER
License No. 18060)	
)	
RESPONDENTS)	

On March 13, 2013, the Iowa Board of Pharmacy (Board) found probable cause to file a Statement of Charges against Respondent Medicap Pharmacy charging the following counts:

Count I: Failure to Verify a Controlled Substance Prescription, in violation of Iowa Code section 155A.15(2)(c) and 657 IAC 8.8(3)¹, 10.21(1), 10.21(2) and 36.1(4)(u);

Count II: Failure to Implement Continuing Quality Improvement Program, in violation of Iowa Code section 155A.15(2)(c) and 657 IAC 8.26 and 36.4(u); and

Count III: Failure to Properly Train Pharmacy Technicians, in violation of Iowa Code section 155A.15(2)(c) and 657 IAC 8.14, 8.26(3) and 36.4(u).

On March 13, 2013, the Board also found probable cause to file a Statement of Charges against Respondent Patricia Randel charging the following counts:

Count I: Violating the Duties of a Pharmacist-in-Charge, in violation of Iowa Code section 155A.12(1) and 657 IAC 6.2(1), (9) and 36.1(4)(u);

¹ The reference to 657 IAC 8.8(3) is a typographical error; subrule 8.3(3) is the rule pertaining to pharmacist-documented verification of prescriptions.

Count II: Failure to Verify a Controlled Substance Prescription, in violation of Iowa Code section 155A.12(1) and 657 IAC 10.21(2) and 36.1(4)(u).

The consolidated hearing was held on April 23, 2013 at 9:15 a.m. in the Board Conference Room, 400 SW 8th Street, Des Moines, Iowa. The following members of the Board served as presiding officers for the hearing: Susan Frey, Chairperson; Edward Maier; James Miller; and LaDonna Gratias. Assistant Attorney General Meghan Gavin represented the state. Medicap Pharmacy was self-represented by its owner, Dennis Jorgenson. Patricia Randel appeared and was also self-represented. The hearing was closed to the public at Respondents' request, in accordance with Iowa Code section 272C.6(1) and 657 IAC 35.19(10). Administrative Law Judge Margaret LaMarche assisted the Board in conducting the hearing and was later instructed to prepare the Board's written Decision and Order for their review, in conformance with their deliberations.

THE RECORD

The record includes the testimony of Jennifer Tiffany, R.Ph.; Patricia Randel, R.Ph.; Dennis Jorgenson, R.Ph.; State Exhibits 1-8 (See Exhibit Index for description) and Respondents' Exhibit A.

FINDINGS OF FACT

1. The Board has issued license number 18060 to Patricia Randel, which authorizes her to engage in the practice of pharmacy in the state of Iowa, subject to the laws of the state and the rules of the Board. At all times material to the Statements of Charges, Patricia Randel was employed as the pharmacist-in-charge for the Medicap Pharmacy in Panora, Iowa. (State Exhibit 3; Testimony of Patricia Randel)
2. Dennis Jorgenson is the owner of the Medicap Pharmacy at 615 East Main Street in Panora, Iowa, which has been issued Iowa pharmacy license number 189. Dennis Jorgenson is also part-owner of the Medicap Pharmacy in Audubon, where he serves as the pharmacist-in-charge, and the Medicap Pharmacy in Dallas Center. (Testimony of Dennis Jorgenson; State Exhibit 3)
3. Jennifer Tiffany, R.Ph. is a Compliance Officer employed by the Board. In April 2012, Ms. Tiffany was assigned to investigate a complaint filed by Dr.

Nathan Schneider. Dr. Schneider had received a quarterly report from Wellmark Insurance indicating that he had prescribed controlled substances to patient RB and that the two prescriptions were filled at the Medicap Pharmacy in Panora on October 12, 2011. Dr. Schneider checked his files, and he did not have any record of treating this patient. (Testimony of Jennifer Tiffany; State Exhibit 3)

The two controlled substance prescriptions for RB were written and signed by Dr. Wittkowsi, who was a resident at the time. Dr. Wittkowsi did not have his own DEA number, but he signed both prescriptions and provided the Mercy Clinic general DEA number with his own unique suffix. Dr. Denville Myrie was listed on the prescription hard copies as RB's attending physician. (State Exhibit 3, p. 10; Exhibit 4, p.11)

Medicap Pharmacy processed RB's two prescriptions using the name of Dr. Denville Myrie as the prescriber, rather than the name of Dr. Wittkowsi, who signed the prescription. To further complicate matters, Medicap Pharmacy's computer system apparently had Dr. Schneider's DEA number listed under Dr. Myrie's profile. The Medicap Pharmacy staff filled RB's controlled substance prescriptions using Dr. Schneider's DEA number, even though Dr. Schneider was neither the prescribing doctor nor the attending physician. Patricia Randel is identified as the verifying pharmacist for both of RB's prescriptions. Ms. Randel normally verifies both the doctor's name and DEA number during her final check, but she missed the errors on these two prescriptions. (Testimony of Patricia Randel; State Exhibits 3, 4).

When she was initially questioned by the Board's compliance officer, Patricia Randel was uncertain how Dr. Schneider's DEA number ended up under Dr. Myrie's profile on the pharmacy's computer system. At hearing, Ms. Randel testified that she believed Dr. Myrie had been a resident under Dr. Schneider at one time, and the pharmacy failed to change Dr. Myrie's DEA number when he ceased being a resident. (Testimony of Jennifer Tiffany; Patricia Randel; State Exhibit 3)

4. In May 2012, patient PH complained that the Medicap Pharmacy in Panora had misfilled three of her prescriptions in 2011 and another three prescriptions in 2012. On each occasion, PH took the medications back to pharmacist-in-charge Patricia Randel and spoke to her about the errors. Each time, the pharmacy corrected the errors. PH could not recall any details about the misfills in 2011. PH recalled that her prescriptions for prednisone and

amiloride were both misfilled with the wrong medications in March 2012. She further reported that her prednisone prescription was also misfilled with the wrong medication in January or February 2012. (Testimony of Jennifer Tiffany; State Exhibit 5, pp. 13-14)

During her first visit to the Medicap Pharmacy to investigate PH's complaint, Jennifer Tiffany spoke to staff pharmacist Ilyeen Wiesley and pharmacy technician Dana Stark. Ms. Stark told Jennifer Tiffany that they had been trained on the pharmacy's Continuous Quality Improvement (CQI) program. However neither Ms. Stark nor Ms. Wiesley knew where the CQI program records or policies were kept. When Ms. Wiesley called Patricia Randel to find out where the CQI program records and policies were kept, Ms. Randel told her that the pharmacy had not documented any errors because there had not been any errors. (Testimony of Jennifer Tiffany; State Exhibit 5, pp. 13-14)

Neither Ilyeen Wiesley nor Dana Stark could recall PH coming into the pharmacy to report a misfill of any of her prescriptions. Jennifer Tiffany obtained a copy of PH's prescription record at Medicap Pharmacy. The pharmacist initials on the patient record show that Respondent Patricia Randel verified PH's prescription for prednisone on January 23, 2012 and on March 24, 2012. Ilyeen Wiesley verified PH's prednisone prescription on February 22, 2012. The record also shows that Respondent Patricia Randel verified PH's prescription for amiloride on March 15, 2012. Therefore, Patricia Randel would have been the verifying pharmacist when two misfilled prescriptions were delivered to PH in March 2012. (Testimony of Jennifer Tiffany; State Exhibit 5, p. 14; Exhibit 6)

5. Jennifer Tiffany also obtained a copy of Medicap Pharmacy's written Policies and Procedures, which included the pharmacy's Continuous Quality Control Improvement (CQI) Program. The policies and procedures provided that the pharmacists are responsible for the final check of all prescriptions prior to delivery to the patient. The pharmacy's CQI Program provides, in relevant part, that:

- The program is to be an ongoing, systematic program of standards and procedures to detect, identify, evaluate and prevent medication errors, thereby improving medication therapy and the quality of patient care;

- The pharmacist-in-charge is responsible for ensuring that the program is administered and monitored by the pharmacists and personnel employed by the pharmacy;
- A reportable program event record will be kept of medications errors that reach the patient, including incorrect drug....any incident resulting in or potential harm to the patient. This shall include date and time of the event discovery and names of individuals who discovered, analyzed and determined the plan of action;
- When an event has occurred, the pharmacist shall ensure that these steps have occurred: notification of the patient or patient's caregiver, identifying and communicating directions or processes for correcting the error, and communicating instructions for minimizing any negative impact on the patient;
- Follow up event analysis shall be done to determine if procedural changes need to occur in policies and procedures, systems or processes. A set of indicators will be developed to measure the standards of the program over time; and
- A process of training all personnel of the details of the program will be ongoing and done at least annually.

(Testimony of Jennifer Tiffany; Exhibit 5, p. 15; Exhibit 8)

6. Jennifer Tiffany returned to Medicap Pharmacy a week later to speak directly to Patricia Randel about the misfilled prescriptions. Ms. Randel was able to recall that PH's amiloride prescription had been mistakenly filled with amlodipine once in 2011 and once in 2012. Ms. Randel admitted that she did not complete a CQI event form on either occasion and further admitted that she had not ever filled out a CQI event form since the inception of the CQI regulations. Ms. Randel could not recall any misfills of PH's prednisone prescription. (Testimony of Jennifer Tiffany; Patricia Randel; State Exhibit 5, p. 14; State Exhibit 8, p. 20)

7. Patricia Randel told Jennifer Tiffany that pharmacy technicians fill most of the prescriptions at Medicap Pharmacy. The pharmacy technicians are also supposed to perform the National Drug Code (NDC) check. Ms. Randel admitted that it was possible that the pharmacy technicians failed to notice that the NDC number printed on the stock bottle did not match the NDC number on PH's prescriptions. (Testimony of Jennifer Tiffany; State Exhibit 5, p. 14)

Patricia Randel also told Jennifer Tiffany that her final check of a prescription typically did not include NDC verification, in part because the technicians did not always leave out the stock bottle that they used to fill the prescription. Ms. Randel reported that she usually did a visual verification of the tablet or capsule. (Testimony of Jennifer Tiffany; State Exhibit 5, p. 14)

After Jennifer Tiffany's visit, Patricia Randel reviewed the importance of the NDC check with her pharmacy technicians. Ms. Randel also told Ms. Tiffany that she would also initiate her own NDC checks on all new prescriptions and refills. (Testimony of Jennifer Tiffany; State Exhibit 5, p. 15)

8. The pharmacy's documentation of its training on Continuous Quality Improvement indicated that only one of the three pharmacy technicians working at the pharmacy had been trained on the pharmacy's CQI program. It was documented that Patricia Randel had been trained on the CQI program, but there was no documentation that pharmacist Ilyeen Wiesley had been trained on the program. Patricia Randel admitted that the pharmacy technicians probably did not know what to do if a misfill was presented to them. (Testimony of Jennifer Tiffany; State Exhibit 5, p. 15; State Exhibit 7) At hearing, Respondents submitted documentation of recent CQI training for all of its pharmacists and pharmacy support personnel. (Respondent Exhibit A, p. 1)

9. Following an inspection of the Medicap Pharmacy in Audubon, Dennis Jorgenson developed a new, more detailed CQI Event Form as recommended by the Board's Compliance Officer. (Respondent Exhibit A, p. 2) The new form is now also being used at the Medicap Pharmacy in Panora. (Testimony of Dennis Jorgenson)

CONCLUSIONS OF LAW

Pursuant to Iowa Code sections 155A.12(1) and 155A.15(2)(c)(2011), the Board is authorized to discipline both pharmacists and pharmacies for any violation of Iowa Code chapter 155A or any rule of the Board. In addition, 657 IAC 36.1(4)"u" provides that the Board may impose any of the disciplinary sanctions set out in subrule 36.1(2) when it determines that a licensee, registrant, or permittee is guilty of violating any of the grounds for revocation or suspension of a license or registration listed in Iowa Code sections 147.55, 155A.12, 155A.15 or any rules of the board.

***Failure to Properly Verify a Controlled Substance Prescription
[Count I: Respondent Medicap Pharmacy; Count II: Respondent Patricia Randel]***

The pharmacist shall provide and document the final verification for the accuracy, validity, completeness, and appropriateness of the patient's prescription or medication order prior to the delivery of the medication to the patient or the patient's representative. 657 IAC 8.3(3).

All prescriptions for controlled substances must bear the name, address, and DEA registration number of the prescriber. All prescriptions issued by the individual prescribers shall include the legibly preprinted, typed, or hand-printed name of the prescriber as well as the prescriber's written or electronic signature. 657 IAC 10.21(1).

657 IAC 10.21(2) provides that the pharmacist shall verify the authenticity of the prescription with the individual prescriber or the prescriber's agent in each case when a written or oral prescription for a Schedule II controlled substance is presented for filling and neither the prescribing individual practitioner issuing the prescription nor the patient or patient's agent is known to the pharmacist. The pharmacist is required to record the manner by which the prescription was verified and include the pharmacist's name or unique identifier.

The preponderance of the evidence established that on October 12, 2011, two Schedule II controlled substance prescriptions were filled by Respondents Patricia Randel and Medicap Pharmacy utilizing an incorrect DEA number for the prescribing physician. Medicap Pharmacy staff and verifying pharmacist Patricia Randel failed to verify that the correct DEA number was listed for the prescribing physician prior to delivering the prescription to the patient. Respondent Patricia Randel has violated Iowa Code section 155A.12(1) and 657 IAC 8.3(3), 10.21(1), 10.21(2), and 36.1(4)(u). Respondent Medicap Pharmacy has violated Iowa Code section 155A.15(2)(c) and 657 IAC 8.3(3), 10.21(1), 10.21(2), and 36.1(4)(u).

***Violating the Duties of a Pharmacist-in-Charge
[Count I: Respondent Patricia Randel]***

657 IAC 6.2 provides, in relevant part:

657-6.2(155A) Pharmacist in charge. One professionally competent, legally qualified pharmacist in charge in each pharmacy shall be responsible for, at a minimum, the following:

1. Ensuring that the pharmacy utilizes an ongoing, systematic program for achieving performance improvement and ensuring the quality of pharmaceutical services.

...

9. Training pharmacy technicians and pharmacy support persons.

...

The preponderance of the evidence established that Respondent Patricia Randel violated Iowa Code section 155A.12(1) and 657 IAC 6.2(1),(9) and 36.1(4)(u) when she failed to properly fulfill her duties as the pharmacist-in-charge of Medicap Pharmacy. Ms. Randel failed to ensure that Medicap Pharmacy utilized an ongoing, systematic CQI program. She also failed to ensure that Medicap Pharmacy's pharmacy technicians were properly trained on the pharmacy's policies and procedures and on its CQI Program. Ms. Randel admits that she knew that at least two of PH's prescriptions were misfilled. It is likely that there were additional misfills that PH brought to the attention of Ms. Randel or other pharmacy staff. However, no errors were documented on the pharmacy's CQI record. In addition, the pharmacy's employees (pharmacist and pharmacy technician) were unable to locate the CQI program and records for the Board's agents. Only one pharmacy technician and Ms. Randel had been trained on the CQI program, according to the CQI documentation.

***Failure to Implement Continuing Quality Improvement Program
[Count II: Respondent Medicap Pharmacy]***

657 IAC 8.26 requires all licensed pharmacies to implement and participate in a continuous quality improvement program or CQI program. The CQI program is intended to be an ongoing, systematic program of standards and procedures to detect, identify, evaluate, and prevent medication errors, thereby improving medication therapy and quality of patient care.

The pharmacist in charge is responsible for ensuring that the pharmacy utilizes a CQI program consistent with the requirements of the rule. 657 IAC 8.26(2). Each pharmacy shall develop, implement, and adhere to written policies and procedures for the operation and management of the pharmacy's CQI program. A copy of the pharmacy's CQI program description and policies and procedures shall be maintained and readily available to all pharmacy personnel. 657 IAC 8.26(3).

The preponderance of the evidence established that Respondent Medicap Pharmacy violated Iowa Code section 155A.15(2)(c) and 657 IAC 8.26 and 36.1(4)(u) by its failure to implement a Continuing Quality Improvement Program. Although the pharmacy had a written CQI Program, it was not being properly implemented. Staff was not documenting medication errors, and the pharmacy's staff members were not properly trained on the CQI program. In addition, the pharmacy was not maintaining any internal CQI data, and it does not appear that the pharmacy is conducting any evaluation or analysis of the types of errors that are occurring in the pharmacy. The pharmacy's owner and its pharmacist-in-charge were unable to adequately articulate the pharmacy's CQI process. It appeared to the Board that they did not fully understand the critical importance of a pharmacy's CQI program to the public health and safety.

Failure to Properly Train Pharmacy Technicians
[Count III: Respondent Medicap Pharmacy]

657 IAC 8.14 provides that all Iowa licensed pharmacies utilizing pharmacy technicians or pharmacy support persons shall develop, implement, and periodically review written policies and procedures for the training and utilization of pharmacy technicians and pharmacy support persons appropriate to the practice of pharmacy at that licensed location. Pharmacy policies shall specify the frequency of review. Pharmacy technician and pharmacy support person training shall be documented and maintained by the pharmacy for the duration of employment. Policies and procedures and documentation of pharmacy technician and pharmacy support person training shall be available for inspection by the board or an agent of the board.

The preponderance of the evidence established that Respondent Medicap Pharmacy violated Iowa Code section 155A.15(2)(c) and 657 IAC 8.15, 8.26(3) and 36.1(4)(u) by failing to properly train and document the training of its pharmacy technicians on the pharmacy's CQI Program and procedures.

DECISION AND ORDER

IT IS THEREFORE ORDERED that Citations and Warnings shall be issued to Respondent Medicap Pharmacy and to Respondent Patricia Randel. Respondents are hereby CITED for the violations established by this record and are WARNED that future violations will result in greater discipline of their licenses.

IT IS FURTHER ORDERED that Respondent Patricia Randel shall pay a civil penalty in the amount of \$500, and Respondent Medicap Pharmacy shall pay a civil penalty in the amount of \$1000. The civil penalty payments shall be made by check, payable to the Treasurer of Iowa, and mailed to the executive director of the Board within thirty (30) days of the issuance of this Decision and Order. All civil penalty payments shall be deposited into the State of Iowa general fund.

IT IS FURTHER ORDERED that within thirty (30) days of this Decision and Order, Respondents Medicap Pharmacy and Patricia Randel shall submit updated Policies and Procedures and an updated Continuous Quality Improvement Program to the Board for its review and approval.

IT IS FURTHER ORDERED that for a one year period, Respondents Medicap Pharmacy and Patricia Randel shall file sworn quarterly reports with the Board that attest to:

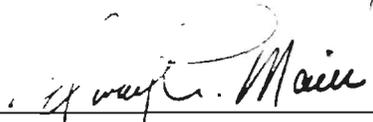
- Their efforts to fully implement the updated and approved Policies and Procedures and Continuous Quality Improvement Program;
- The process used to train all pharmacists and pharmacy technicians on the Policies and Procedures and the Continuous Quality Improvement Program; and
- An explanation of the indicators being used to measure quality improvement.

The reports shall be filed no later than June 5, 2013, September 5, 2013, December 5, 2013, and March 5, 2014. Respondent's quarterly reports shall also provide any other information deemed to be necessary by the Board.

IT IS FURTHER ORDERED, pursuant to Iowa Code section 272C.6 and 657 IAC 36.18(2), that Respondents Medicap Pharmacy and Patricia Randel shall pay

\$75.00 for fees associated with conducting the disciplinary hearing. In addition, the executive secretary/director of the Board may bill Respondents for any witness fees and expenses or transcript costs associated with this disciplinary hearing. Respondent shall remit for these expenses within thirty (30) days of receipt of the bill.

Dated this 9th day of May, 2013.



Susan Frey, Chairperson
Iowa Board of Pharmacy

cc: Meghan Gavin, Assistant Attorney General

Any aggrieved or adversely affected party may seek judicial review of this decision and order of the board, pursuant to Iowa Code section 17A.19.