

BEFORE THE IOWA BOARD OF PHARMACY

Re:)	Case Nos. 2013-45 & 2013-91
Pharmacy License of)	
WYOMING DRUG)	STATEMENT OF CHARGES
License No. 390,)	& 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) (2013). Respondent was issued Iowa license 390. Respondent's license is currently active.

A. TIME, PLACE, AND NATURE OF HEARING

Hearing. A disciplinary contested case hearing shall be held on April 29, 2014, 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 over this matter pursuant to Iowa Code chapters 17A, 147, 155A, and 272C.

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, 155A, and 272C 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

UNETHICAL BEHAVIOR OR PRACTICE HARMFUL OR DETRIMENTAL TO THE PUBLIC

Respondent is charged with engaging in unethical behavior or practice harmful or detrimental to the public in violation of Iowa Code section 155A.15(2)(e) and 657 Iowa Administrative Code rule 36.1(4)(c).

Count II

FAILURE TO MAINTAIN A CQI PROGRAM

Respondent is charged with failing to maintain a continuous quality improvement program in violation of Iowa Code section 155A.15(2) and 657 Iowa Administrative Code rules 8.3(1), 8.26, and 36.1(4)(u).

Count III

FAILURE TO VERIFY PRESCRIPTION

Respondent is charged with failing to verify a prescription in violation of Iowa Code section 155A.15(2) and 657 Iowa Administrative Code rule 8.3(1), 8.3(3), and 36.1(4)(u).

D. FACTUAL CIRCUMSTANCES

Case 2013-45

1. On May 14, 2013 the Board opened a complaint against the Respondent and pharmacist-in-charge Phil Teuken. The complaint alleged the Respondent filled numerous

forged prescriptions for Hydromorphone 8mg.

2. On December 10, 2012, the Respondent received a drug alert from Finley Hospital Pain Clinic advising of forged prescriptions for Hydromorphone 8mg listing Dr. Tim Miller as the prescriber.

3. The Respondent continued to fill prescriptions for Hydromorphone 8mg following the alert, without consulting the prescriber.

4. Several of the forged prescriptions were "signed" by Dr. Miller. In addition to the alert, Dr. Miller had previously informed the Respondent that he did not prescribe Hydromorphone 8mg.

Case 2013-91

1. On May 10, 2013 a complaint was filed against the Respondent and pharmacist-in-charge Phil Tuetken. The complaint alleged several dispensing errors.

2. Numerous errors were made regarding patient C.W.'s medications, including C.W.'s insulin prescription was issued in his granddaughter's name, a Warafarin prescription was filled without request, and one of C.W.'s wife prescriptions was incorrectly filled with a medication not covered by her insurance.

3. None of the errors were recorded in a Continuous Quality Improvement 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 the 12th day of March, 2014, the Iowa Board of Pharmacy found probable cause to file this Notice of Hearing and Statement of Charges.



EDWARD MAIER, Chairperson
Iowa Board of Pharmacy
400 SW Eighth Street, Suite E
Des Moines, Iowa 50309-4688

cc: Meghan Gavin

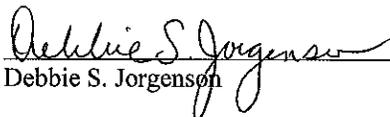
Assistant Attorney General
Hoover State Office Building
Des Moines, Iowa

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 <u>9171999991703239255035</u> | <input type="checkbox"/> other _____ |
| on the <u>13th</u> day of <u>March</u> , 20 <u>14</u> . | |

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:)	
)	
Pharmacist License of)	Docket Nos. 2013-45 & 2013-91
PHILLIP TUETKEN)	DIA No. 14PHB010
License No. 12514)	
)	
Pharmacy License of)	
WYOMING DRUG)	
License No. 390)	
)	
Respondents.)	FINDINGS OF FACT,
)	CONCLUSIONS OF LAW,
)	DECISION, AND ORDER

STATEMENT OF THE CASE

On March 12, 2014, the Iowa Board of Pharmacy (Board) found probable cause to file a Statement of Charges & Notice of Hearing against Respondents Phillip Tuetken and Wyoming Drug. The Statement of Charges alleges that Respondents Tuetken and Wyoming Drug: 1) engaged in unethical behavior or practice harmful or detrimental to the public; 2) failed to maintain a CQI program; and 3) failed to verify a prescription. Additionally, the Statement of Charges alleges that Respondent Tuetken violated the duties of a pharmacist-in-charge.

The hearing was held on June 30, 2014. The following members of the Board presided at the hearing: Edward Maier, Chairperson; James Miller; LaDonna Gratias; Susan Frey; Judith Trumpy; and Edward McKenna. Respondents appeared and were represented by attorney Nick Strittmatter. Assistant attorney general Meghan Gavin represented the State. The hearing was closed to the public at the election of Respondents, pursuant to Iowa Code section 272C.6(1). The hearing was recorded by a certified court reporter. Administrative Law Judge Laura Lockard assisted the Board in conducting the hearing and was instructed to prepare the Board's written decision in accordance with its deliberations.

THE RECORD

The record includes the Notice of Hearing and Statement of Charges with regard to both Respondents. The record also includes hearing testimony of Curt Gerhold and Phillip Tuetken. The State introduced Exhibits 1 through 17, which were admitted as evidence. Respondents introduced Exhibit A, which was admitted as evidence.

FINDINGS OF FACT

Respondent Wyoming Drug holds Iowa pharmacy license number 390, which is currently active. Respondent Phillip Tuetken holds Iowa pharmacist license number 12514, which is currently active. At all times relevant to this action, Tuetken was employed at Wyoming Drug in Wyoming, Iowa as pharmacist-in-charge. Tuetken has been a licensed pharmacist since approximately 1959. He has worked at Wyoming Drug for the last four to five years and works approximately 35 to 40 hours per week.

Complaint 1: Forged Hydromorphone Prescriptions

In mid-December 2012, Amy Moet, a relief pharmacist who works one to two days per month at Wyoming Drug, alerted the Board that Wyoming Drug had been filling forged prescriptions for hydromorphone 8 mg tablets. Curt Gerhold, a compliance officer for the Iowa Board of Pharmacy, was assigned to investigate the matter. Gerhold interviewed Moet, who informed him that she had a prescription come in from Dr. Tim Miller for hydromorphone 8 mg that looked suspicious. Moet called Finley Pain Clinic, where Dr. Miller practices, on December 6, 2012 to inquire whether the prescription was valid. Moet was informed by the clinic that Dr. Miller does not write prescriptions for hydromorphone. After receiving this information, Moet went through all of the hydromorphone prescriptions that Wyoming Drug had filled recently that were purportedly written by Dr. Miller. Moet checked with Dr. Miller's office and determined that all of these prescriptions were forged. (Exh. 5; Gerhold testimony).

As a result of Moet's call, Finley Pain Clinic generated a drug alert form to be sent to all pharmacies in the area. Additionally, the clinic filed a report with the Jones County Sheriff's Department on December 17, 2012. (Exh. 6, 7).

Gerhold visited Wyoming Drug on or about December 18, 2012 and spoke with Tuetken about the forged hydromorphone prescriptions. Tuetken was aware of the issue of the forged prescriptions because he had been visited by a representative of the sheriff's office that day or the prior day, who had taken copies of records related to six months of hydromorphone prescriptions filled by Wyoming Drug. Gerhold advised Tuetken that all of the hydromorphone prescriptions that had been filled in the last six months by Wyoming Drug were forged. Gerhold wrote down for Tuetken the list of 13 names that Moet had generated of individuals who had filled forged hydromorphone prescriptions at Wyoming Drug. Tuetken indicated that he would not fill hydromorphone prescriptions for members of the family in question without contacting the prescribing physician to verify the legitimacy of the prescription. (Gerhold testimony; Exh. 5).

On March 1, 2013, Moet sent Gerhold an e-mail indicating that prescriptions for hydromorphone 8 mg were still being filled at Wyoming Drug. On March 20, 2013, Gerhold visited Wyoming Drug to obtain copies of the hydromorphone prescriptions that had been filled. At that time, Gerhold asked Tuetken if any of the individuals on the list of 13 that Gerhold had provided Tuetken in December had tried to fill additional hydromorphone prescriptions. Tuetken responded that he did not know. Upon review, Gerhold discovered that six individuals had filled forged prescriptions for

hydromorphone subsequent to his December 18, 2012 visit to the pharmacy; all of those individuals were on the list that Gerhold provided to Tuetken during that visit. The pharmacy dispensed a total of 720 tablets of hydromorphone 8 mg between January and March 2013, after Gerhold's initial visit with Tuetken. (Exh. 5; Gerhold testimony).

Prior to Tuetken's initial discussion with Gerhold in December 2012, Tuetken had filled two prescriptions for morphine and a morphine derivative for a single patient, F.B., very close in time. Tuetken filled a prescription for 120 pills of morphine on November 29, 2012, then another prescription for 120 pills of hydromorphone 8 mg on December 4, 2012. According to Gerhold, a single patient filling these two prescriptions so close in time should raise a red flag for a pharmacist. Pharmacies maintain patient profiles, and it should be relatively easy for a pharmacist to access a particular patient's prescription history. (Exh. 10, Gerhold testimony).

Tuetken could not say definitively at hearing whether the computer system that Wyoming Drug uses has an auto alert that alerts a pharmacist to a drug interaction (for example, duplicate therapy). Tuetken testified that he did not recall filling a second prescription for F.B. for morphine just six days prior to the hydromorphone prescription she presented. He acknowledged that he should have recalled this, but did not. Tuetken then filled another prescription for F.B. for hydromorphone 8 mg dated March 8, 2013, after he had already been informed that the previous prescriptions she filled were forged. (Exh. 10; Gerhold, Tuetken testimony).

At hearing, Tuetken testified that he did not know why he did not call Dr. Miller's office when he received additional prescriptions for hydromorphone 8 mg after Gerhold's December visit. Tuetken acknowledged that he should have done so and that hydromorphone is not a prescription that is commonly filled at Wyoming Drug. (Tuetken testimony).

Complaint 2: Errors Filling Legitimate Prescriptions

In May 2013, the Board received a second complaint regarding Wyoming Drug and Tuetken from UnityPoint Clinic Family Medicine in Clarence, Iowa. Mary Coon, an RN at UnityPoint Clinic Family Medicine, reported to the Board that a patient of the clinic, C.W., as well as his wife, reported several medication errors by Wyoming Drug and Tuetken. (Exh. 13, pp. 47-48).

First, C.W. had his insulin prescription filled by Tuetken at Wyoming Drug and it was erroneously filled in the name of C.W.'s granddaughter, who has the same last name but a different first name. The family returned the insulin to the pharmacy and the error was corrected. (Exh. 13, p. 48).

Second, C.W.'s wife called in in May 2013 and asked for a refill on some of his medications after a stay at a nursing facility. When C.W.'s wife picked up the medications, she noticed that Tuetken had filled a prescription for warfarin, which C.W. had not been taking for years. The last warfarin prescription on file for C.W. was written

on October 17, 2011. The prescription provided for a 60-day supply and four refills. (Exh. 14, 15).

On May 28, 2013, Gerhold met with Tuetken to discuss the prescription errors that had been reported. There was no incident report available for either of the errors. At hearing, Tuetken testified that he did not have any recollection of the situation where C.W.'s medication was mislabeled with his granddaughter's name. (Exh. 14; Tuetken testimony).

With regard to the warfarin incident, Tuetken testified that C.W.'s wife called the pharmacy and asked him to fill C.W.'s maintenance prescriptions. According to Tuetken, he was unable to get ahold of C.W.'s wife by telephone, therefore assumed that C.W. needed warfarin because it was past time for the prescription to be filled. Tuetken recalled that C.W. had been on warfarin previously. (Tuetken testimony).

When asked at hearing about whether Wyoming Drug has a continuous quality improvement (CQI) program in place, Tuetken testified that he keeps track of errors at the pharmacy mentally. (Tuetken testimony).

Tuetken was unable to describe with specificity at hearing the computer system that Wyoming Drug uses to track and verify prescriptions. Tuetken testified that if he fills a prescription himself at the pharmacy and there is no pharmacy tech on site he is the person who does all of the required steps, including data entry, filling the prescription, and verifying the prescription. Tuetken testified that the computer system does not allow him to compare the finished bottle with the original prescription at the same time. Tuetken testified that all he can review when he is verifying the prescription after it has been filled is what he manually entered into the computer system, not the original prescription that the patient presented. (Tuetken testimony).

With regard to the labeling error for C.W.'s insulin prescription, Tuetken testified that there is a way for the computer system to have caught the name difference in the final verification process. He did not specify why that did not occur in that particular case. (Tuetken testimony).

With regard to the pharmacy's policies and procedures, Tuetken testified that these are done at a "central place." He testified that he does not develop policies and procedures for the pharmacy. (Tuetken testimony).

CONCLUSIONS OF LAW

Count I: Unethical Behavior or Practice Harmful or Detrimental to the Public

The Board is authorized to impose a disciplinary sanction on a licensee when the licensee knowingly makes misleading, deceptive, untrue or fraudulent representations in the practice of pharmacy or engages in unethical conduct or practice harmful or

detrimental to the public. It is not necessary that there be proof of actual injury for a violation to be found.¹

The undisputed evidence in this case demonstrates that Tuetken, the pharmacist-in-charge at Wyoming Drug, continued filling forged prescriptions for hydromorphone even after being warned by both a compliance officer from the Board and the sheriff's office that all of the prescriptions that the pharmacy had filled in the six months prior to December 2012 for hydromorphone were forged. Tuetken acknowledged that hydromorphone was not commonly filled at Wyoming Drug, yet despite this fact he nevertheless dispensed 720 more pills from prescriptions forged with Dr. Miller's name over the course of three months after being informed of the forgeries.

While Tuetken repeatedly emphasized at hearing his belief that Wyoming Drug did not receive a copy of the drug alert that was issued by Dr. Miller's office after they discovered the forgeries, the Board does not believe that whether or not Wyoming Drug received the drug alert mitigates Tuetken's conduct. The drug alert would have added nothing to what Tuetken had already been personally informed by the Board's compliance officer and the sheriff's office. It is difficult to imagine that the drug alert would have changed Tuetken's conduct in a way that those notifications did not.

While that conduct alone would have been enough to find a violation under this count, the evidence also demonstrates that Tuetken committed at least one labeling error and filled at least one expired prescription during the relevant time period. In his testimony at hearing, Tuetken exhibited a shocking lack of familiarity with the computer system that Wyoming Drug utilizes and was unable to describe in any detail safeguards that have been put in place to prevent errors of the sort that he committed.

Tuetken was acting as pharmacist-in-charge at Wyoming Drug during the time period in question and there is no evidence that the pharmacy had in place any safeguards to prevent the sort of large-scale dispensing of schedule II narcotics based on forged prescriptions that occurred there. The pharmacy was aware of the high likelihood of forgery and took no steps to prevent filling forged prescriptions.

Dispensing large quantities of schedule II narcotics without a valid prescription is harmful and detrimental to the public. The preponderance of the evidence demonstrates that Respondent Tuetken and Respondent Wyoming Drug committed a violation of 657 Iowa Administrative Code 36.1(4)(c).

Count II: Failure to Maintain a CQI Program

The Board's regulations provide that the pharmacy and the pharmacist-in-charge share responsibility for ensuring that all operations of the pharmacy are in compliance with federal and state laws, rules, and regulations relating to pharmacy operations and the practice of pharmacy.² All licensed pharmacies in Iowa are required to implement or

¹ Iowa Code § 155A.12(2) (2013); 657 Iowa Administrative Code 36.1(4)(c).

² 657 IAC 8.3(1).

participate in a continuous quality improvement (CQI) program.³ The pharmacist in charge is responsible for ensuring that the pharmacy utilizes a CQI program consistent with the requirements of 657 Iowa Administrative Code 8.26.⁴

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 the quality of patient care.⁵

A pharmacy is required to develop, implement, and adhere to written policies and procedures for operation and management of the CQI program. The policies and procedures must address a process to identify and document reportable program events. A reportable program event is a preventable medication error that results in the incorrect dispensing of a prescribed drug, including an incorrect drug dispensed, incorrect labeling, or a drug received by the wrong patient.⁶

The preponderance of the evidence demonstrates in this case that Respondent Tuetken and Respondent Wyoming Drug violated Iowa Code section 155A.12(1) and 657 Iowa Administrative Code 8.26, and 36.1(4)(u) by failing to have a CQI program compliant with the Board's requirements. In response to questioning on this issue at hearing, Tuetken could not identify any CQI program. Tuetken stated that he keeps tracks of errors mentally; there is no evidence that Wyoming Drug keeps any written record of reportable events, as required by the Board's regulations. No written incident report was available for either the incorrect labeling of C.W.'s insulin with his granddaughter's name or for the incorrect dispensing of warfarin to C.W. after the prescription had expired.

Count III: Failure to Verify Prescription

Pursuant to the Board's regulations, the pharmacist must provide and document the final verification for accuracy, validity, completeness, and appropriateness of a patient's prescription or medication order prior to the delivery of the medication to the patient or to the patient's representative.⁷ The pharmacy and pharmacist-in-charge share responsibility for making sure that procedures are in place to ensure such verification is occurring.⁸

The evidence here demonstrates that in more than one instance Tuetken failed to verify a prescription that resulted in an error that left the pharmacy. Tuetken improperly labeled C.W.'s insulin with his granddaughter's name and then refilled C.W.'s expired prescription for warfarin. Tuetken's explanation at hearing of the pharmacy's system for verification was nearly incomprehensible. Under these circumstances, Respondent

³ 657 IAC 8.26.

⁴ 657 IAC 8.26(2).

⁵ 657 IAC 8.26.

⁶ 657 IAC 8.26(1), (3).

⁷ 657 IAC 8.3(3).

⁸ 657 IAC 8.3(1).

Tuetken and Respondent Wyoming drug committed a violation of 657 Iowa Administrative Code 8.3(3) and 36.1(4)(u).

Count IV: Violating the Duties of a Pharmacist-in-Charge

This charge relates only to Tuetken. Under the Board's regulations, a pharmacist-in-charge is required to, among other things: 1) ensure that the pharmacy utilizes an ongoing, systematic program for achieving performance improvement and ensuring the quality of pharmaceutical services; and 2) ensure the legal operation of the pharmacy, including meeting all inspection and other requirements of state and federal laws, rules, and regulations governing the practice of pharmacy.⁹

As discussed above, with regard to Count II, Tuetken failed to ensure that Wyoming Drug utilized an ongoing, systematic CQI program. Tuetken did not document either of the reportable events that were discovered during the Board's investigation. Tuetken appeared to have no knowledge of the Board's requirement for a CQI program utilizing written documentation of reportable events; instead, he testified that he keeps track of errors mentally. The preponderance of the evidence establishes a violation of 657 Iowa Administrative Code 6.2(2) and 6.2(15).

Sanction

The Board may consider a number of factors in determining the nature and severity of the disciplinary sanction to be imposed when a violation is established, including the relative seriousness of the violation as it relates to assuring a high standard of professional care; the facts of the violation; any extenuating circumstances; whether remedial action has been taken; and any other factors that reflect upon the competency, ethical standards, and professional conduct of the licensee.¹⁰

The Board has extremely serious concerns about Tuetken's ability to safely practice pharmacy. As discussed above, Tuetken ignored the warnings of the Board's compliance officer and the sheriff's office regarding forged prescriptions coming into the pharmacy purporting to be from Dr. Miller. The warnings were not speculative; the pharmacy had already filled a number of the forged prescriptions prior to December 2012. Despite the warnings, Tuetken dispensed 720 more pills on the basis of forged prescriptions in the three months following the warnings. Not only that, Tuetken appears to lack insight into the magnitude of the violation and his role in creating it; at hearing, Tuetken repeatedly emphasized his belief that Wyoming Drug had not received the drug alert from Finley Pain Clinic. Regardless of whether or not the official drug alert had been received, Tuetken had been alerted by both the Board and the sheriff's office that he had filled forged prescriptions. There should have been no additional information needed for Tuetken to take swift, corrective action. None was taken.

⁹ 657 IAC 6.2(2), (15).

¹⁰ 657 IAC 36.1(3).

As discussed above, Tuetken did not demonstrate a comprehensive understanding at hearing of either the need to verify a filled prescription against the prescription that comes into the pharmacy, nor any systems in place at Wyoming Drug to do so. Tuetken's lack of care in this regard resulted in at least two prescription errors that left the pharmacy without being caught. No record was made of those errors by the pharmacy, even after the pharmacy was alerted. The errors were only reported to the Board when the individual who received the prescriptions notified his health care provider, who made the report. Without evidence that there are any systems in place to prevent these types of errors from happening, it is impossible to know how many other such errors may be occurring on a regular basis at this pharmacy.

The Board likewise has serious concerns about Wyoming Drug's compliance with the laws and regulations applicable to the practice of pharmacy. Tuetken has been the pharmacist-in-charge for several years and it does not appear that any action has been taken regarding the systemic errors that have been occurring over his tenure.

Finally, despite the severity of the violations, there is no evidence that, to date, either Wyoming Drug or Tuetken have taken any steps to address the problems have been identified by the Board.

DECISION AND ORDER

IT IS THEREFORE ORDERED that Respondent Phillip Tuetken's license shall be suspended indefinitely effective upon issuance of this order. Pursuant to 657 Iowa Administrative Code 36.13(1), no application for reinstatement shall be made until at least one year has elapsed from the date of this order.

IT IS FURTHER ORDERED that Respondent Phillip Tuetken shall have no involvement in the ownership, management, direction, or control of any business engaged in the practice of pharmacy during the time that his license is suspended.

IT IS FURTHER ORDERED that Respondent Phillip Tuetken shall pay a civil penalty in the amount of \$3,500. The civil penalty payment shall be made by check, payable to the Treasurer of Iowa, and mailed to the executive director of the Board within 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 Respondent Wyoming Drug's license shall be placed on probation for a period of two years.

IT IS FURTHER ORDERED that Respondent Wyoming Drug shall, within 30 days of the date this Order is issued, designate a new pharmacist in charge for Wyoming Drug by submitting a new license application which indicates a change of PIC, along with the required fee of \$135, to the Board office.

IT IS FURTHER ORDERED that, as a condition of probation, Respondent Wyoming Drug shall require that its pharmacist-in-charge sign up for and effectively utilize the Iowa Prescription Monitoring Program (PMP).

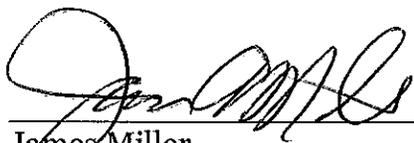
IT IS FURTHER ORDERED that, as a condition of probation, Respondent Wyoming Drug shall file sworn quarterly reports to the Board. The reports shall be filed no later than the 5th day of March, June, September, and December of each year. The quarterly reports shall describe Respondent Wyoming Drug's compliance with the terms of this order, including the requirement that the pharmacist-in-charge sign up for and utilize the PMP. Additionally, the quarterly reports shall describe Respondent's implementation of its written CQI program.

IT IS FURTHER ORDERED that Respondent Wyoming Drug shall, within 30 days of the date this order is issued, submit to the Board for its approval a copy of policies and procedures unique to Wyoming Drug, including a Continuous Quality Improvement program. Once the policies and procedures are approved by the Board, Respondent Wyoming Drug shall implement and follow the policies and procedures.

IT IS FURTHER ORDERED that Respondent Wyoming Drug shall pay a civil penalty in the amount of \$3,500. The civil penalty payment shall be made by check, payable to the Treasurer of Iowa, and mailed to the executive director of the Board within 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 pursuant to Iowa Code section 272C.6 and 657 Iowa Administrative Code 36.18(2), that Respondent Wyoming Drug and Respondent Phillip Tuetken shall pay \$75 for fees associated with conducting the disciplinary hearing. In addition, the executive secretary/director of the Board may bill Respondent for any witness fees and expenses or transcript costs associated with this disciplinary hearing. Respondent shall remit for these expenses within 30 days of receipt of the bill.

Dated this 26th day of August, 2014



James Miller
Vice-Chairperson, Iowa Board of Pharmacy

cc: Meghan Gavin, Assistant Attorney General
Nick Strittmatter, Attorney for Respondent

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.