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BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

IX. Discussion and Possible Action to Make Changes in Response to Comments or to Adopt or Amend Proposed Text at Title 16 California Code of Regulations Sections 1735 e seq. and 1751 et seq. Relating to Pharmacy Compounding

At the October 2013 Board Meeting, the board moved to initial notice of proposed changes in the California's compounding regulations (located in 16 California Code of Regulations Sections 1735 et seq. and 1751 et seq). The 45 day comment period ran from November 29, 2013 – January 13, 2014. A regulation hearing was held on January 16, 2014 to provide the public with an opportunity to provide comments in another forum. At the January 2014 board meeting, the board made a motion to allow the sterile compounding workgroup to work through the comments received and submit a second version of the proposed text based on comments. At the April 2014 Board meeting, the Board voted to withdraw the current compounding rulemaking, revise the language to incorporate many of the comments submitted in response to the initial regulation notice and notice the new language as a new rulemaking.

At the July 2014 Board Meeting, the board moved to initial notice of proposed changes in the California's compounding regulations (located in 16 California Code of Regulations Sections 1735 et seq. and 1751 et seq). The 45 day comment period ran from September 5, 2014 – October 20, 2014. A regulation hearing was held on November 4, 2014 to provide the public with an opportunity to provide comments in another forum.

At the January 2015 Board Meeting, the board adopted the revised language incorporating many of the comments submitted during the 45 day comment period, and voted to notice the revised language for a 15 day comment period. The 15 day comment period ran from February 6, 2015 – February 20, 2015.

At the March 2015 Board Meeting, the board adopted the revised language incorporating many of the comments submitted during the 15 day comment period, and voted to notice the revised language for a second 15 day comment period. The second 15 day comment period ran from March 11, 2015 – March 25, 2015.

Attachment 1 is a compilation document of the written comments received during the 45 day comment period. Board Manager Lori Martinez sorted all written comments received by section number, so members can review all related comments together.

Attachment 2 is a compilation document of the written comments received during the first 15 day comment period. Board Manager Lori Martinez sorted all written comments received by section number, so members can review all related comments together.

Attachment 3 is a compilation document of information about the November Regulation Hearing, a clean version of the current regulation language, and the written comments received during the second 15 day comment period. Board Manager Lori Martinez sorted all written comments received by section number, so members can review all related comments together.

Attachment 4 is the current regulation language as noticed on March 11, 2015.

<u>At this Meeting</u>

The board will have the opportunity to discuss the regulation, the comments received and determine what course of action it wishes to pursue. Among its options:

1. Adopt the regulation as approved at the March 2015 Board meeting
2. Amend the regulation in some way(s) to address concerns expressed in the second 15 day comment period
3. Withdraw the current rulemaking file originally noticed September 24, 2014 and provide general guidance to board staff to develop new updated language based on substantive comments received by the board and notice the revised language as a new rulemaking.

Attachment 1

Code Section	Commenter	Comment
1735	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	What is the basic purpose of this level of record keeping for a hospital pharmacy when one of the requirements is not the patient's name (e.g., not used for recalls)?
1735(a)	PharMEDium Services, LLC Rich Kruzynski	"Compounding" means any of the following activities occurring in a licensed pharmacy or outsourcing facility, by or under the supervision of a licensed pharmacist ~~pursuant to a prescription~~:
1735(b)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	One of the major topics in the proposed regulation changes deals with new parameters for ophthalmic medications. Though some interpretations of the term "topical" may include ophthalmic solutions and suspensions, this sub-section's meaning would be more clear of the term "ophthalmic" was added after the term "topical".
1735(c)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	This sub-section's meaning has been misunderstood and should be changed in this regulatory change process since the Board of Pharmacy is proposing a change in this sub-section. By defining in this sub-section what is NOT compounding in previous sub-section "(b)" and thus defining activities that are NOT subject the regulations and then doing the same for this sub-section "(c)" it has been interpreted that such activities are also not subject to the regulation. Conversely, it has been interpreted that the intent of this sub-section is just the opposite, i.e. that other than in "small quantities …" preparation of a product that is commercially available or is essentially a copy of a commercially available, though allowed for shortages per a subsequent regulation in the proposed changes, IS compounding and subject to these regulations. Also the change of the term "product" to "preparation" as proposed further confuses the sub-section as it is the intent of the Board to use the term "preparation" when something is pharmacy-compounded and the term "product" when the medication is commercially available.
1735(c)	Central Admixture Pharmacy Services, Inc William Jones	"Product" should not be changed to "preparation" in this case. One would be making a copy of an approved drug product by compounding a sterile preparation.
1735(c)	Douglas Barcon, Pharm.D., Barcon & Associates	Consider adding a limitation at the end of the last sentence by addressing paragraph (d)(3) in 1735.2. Compounding Limitations and Requirements; Self-Assessment.

Code Section	Commenter	Comment
1735.1	California Pharmacist Association Brian Warren	We recommend the following modifications to Section 1735.1: “Daily” means occurring every day that a pharmacy is operating. “Primary Engineering Control (PEC)” means a device that provides an ISO Class 5 environment or better through the use of unidirectional HEPA filtered first air. Specific PEC devices include, but are not limited to, laminar airflow workbenches, biological safety cabinets, compounding aseptic isolators, and compounding aseptic containment isolators. “Segregated sterile compounding area” means a designated space where a ~~device that provides unidirectional airflow of ISO Class 5 air quality, including compounding aseptic isolators~~, PEC is located within either a demarcated area (at least three foot perimeter) or room. Such area shall **not** contain and shall be void of activities and materials that are extraneous to sterile compounding. The segregated **sterile** compounding area shall not be in a location that has unsealed windows or doors that connect to the outdoors, in a location with high traffic flow, or in a location that is adjacent to construction sites, warehouses, or food preparation, and shall not have a sink located within at least three feet of the ~~ISO Class 5~~ PEC. ~~This~~ **The segregated** sterile compounding area ~~will~~ **shall** be restricted to preparing sterile-to-sterile compounded preparations.
1735.1	Douglas Barcon, Pharm.D., Barcon & Associates	Should there be an added definition to this regulation for a tacky mat or similar device to capture and minimize tracking of particles on the floor into the anteroom and ISO Class 7 buffer rooms, and should such a device be required or recommended, or should this be left to the PIC or the institutional or corporate policies and procedures and not codified in regulations?
1735.1	PharMEDium Services, LLC Rich Kruzynski	Add: (2) "Outsourcing facility" means a facility at one geographic location or address that is engaged in anticipatory compounding of sterile drugs and complies with the United States Food and Drug Administration Section 503B of the Federal Food, Drug, and Cosmetic Act.
1735.1	Providence Heath & Services Southern California Region	Providence recommends adding definitions of the following primary engineering controls as per the USP 797 definitions to assist with understanding of the terminology for sterile compounding PECs. Biological Safety Cabinet(BSC): A ventilated cabinet for CSPs, personnel, product, and environmental protection having an open front with inward airflow for personnel protection, downward hiqh-efficiency air (HEPA)-filtered laminar airflow for product protection, and HEPA-filtered exhausted air for environmental protection. Compounding Aspetic Containment Isolator (CACI): A compounding aseptic isolator (CAI) designed to provide worker protection from exposure to undesirable levels of airborne drug throughout the compounding and material transfer processes and to provide an aseptic environment for compounding sterile preparations. Air exchange with the surrounding environment should not occur unless the air is first passed through a microbial retentive filter (HEPA minimum) system capable of containing airborne concentrations of the physical size and state of the drug being compounded. Where volatile hazardous drugs are prepared, the exhaust air from the isolator should be appropriately removed by properly designed building ventilation.

Code Section	Commenter	Comment
1735.1	Providence Heath & Services Southern California Region	Compounding Aseptic Isolator (CAI): A form of isolator specifically designed for compounding pharmaceutical ingredients or preparations. It is designed to maintain an aseptic compounding environment within the isolator throughout the compounding and material transfer processes. Air exchange into the isolator from the surrounding environment should not occur unless the air has first passed through a microbial retentive filter (HEPA minimum)
1735.1(a)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend removing "(also called ante room)" as this is different than what is currently required under regulation. There is a designated buffer area and ante area, and no enclosed "room" requirement.
1735.1(a)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	*1735.1 Compounding Definitions Where appropriate in the definitions section add the following terms:* 1.Add a definition of "adjacent" to allow for hospital construction. 2.Add a definition of "warehouse" to differentiate it from a pharmacy that may be built in a building constructed as a warehouse. 3. Add a definition for single dose container. 4.Add a definition for humidity 1735.1 (a) Ante-Area Recommend removing "(also called ante room)" as this is different than what is currently required under regulation. There is a designated buffer area and ante area, and no room requirement.
1735.1(a)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommended ADDITIONAL Definitions 1. "Prescriber's office" includes traditional unlicensed prescribers offices and licensed health-care facilities where prescribers order, administer and dispense compounded preparations. Rationale: pharmacists compounding in all environments where compounded preparations are used improves the safety of health-care 2. "End-product examination": means a pharmacist will physically examine the final product to ensure that it meets specifications in the master formula. Using the term "end-product examination" and not the terms "end-product evaluation" or "end-product-testing", though possibly considered synonymous will avoid confusion. Using all three terms in the regulations is not only confusing to pharmacist but has been a continued source of confusion for Board Inspectors. Further Rationale: The master formula should contain the parameters for determining a consistent and successful compounding of the preparation regardless of who did the compounding. These parameters would include characteristics determined by the pharmacist in charge based on standards in the industry for compounding

Code Section	Commenter	Comment
1735.1(a)	California Society of Health-System Pharmacists Dawn Benton	Recommend additional definition of “prescriber’s office” to include traditional unlicensed prescribers offices and licensed health-care facilities where prescribers order, administer and dispense compounded preparations. Rationale: pharmacists compounding in all environments where compounded preparations are used improves the safety of health-care. Recommend additional definition “end-product examination”: a pharmacist will physically examine the final product to ensure that it meets specifications in the master formula. Recommend only using the term “end-product examination” and not the terms “end-product evaluation” or “end-product testing” though we consider these to be synonymous. Using all three terms in the regulations is confusing. Rationale: The master formula should contain the parameters for a successful compounding of the preparation. These parameters would include characteristics determined by the pharmacist in charge based on standards in the industry for compounding. Recommend removing “(also called ante room)” as this is different than what is currently required under regulation. There is a designated buffer area and ante area, and no room requirement.
1735.1(a)	Sutter Health Jeannette Hanni	Recommend removal of the parenthesis comment (also called ante-room). It is not a room but a "space".
1735.1(b)	Cedars-Sinai Katherine Palmer Rita Shane	USP 797 defines batches as >25 compounded medications in the context of high risk (non-sterile to sterile) preparations or extended dating. Recommend using the same quantity to define sterile to sterile batches.
1735.1(b)	Sutter Health Jeannette Hanni	Remove "batch" definition as stated. Language already exists associated with low and medium risk compounded sterile preparations (CSPs). The term "batch" should only apply to high-risk CSPs, where end product testing representative samples is specifically required in CA1751.7e and USP797. Recommend redefining "batch" only in the context of high-risk preparations as describe in USP797

Code Section	Commenter	Comment
1735.1(b)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend defining “batch” as a quantity sufficient for sterility testing in high risk compounding preparations e.g. sterile from non-sterile ingredients, and prepared in quantities sufficient for testing sterility and within a period with sufficient time to receive results before required administration and in a quantity that can be tested without destroying all the finished preparation. Rationale: There is no benefit in defining a batch for sterile to sterile transfers, whether for a single dose or multiple doses. There is already language in existing and proposed regulations that limit the risk associated with low and medium risk compounded sterile preparations (CSPs). For example: media fill tests are already required for personnel compounding these types of preparations (1751.7(b)). The term “batch” should only be applicable for high-risk CSPs, where end-product testing of representative samples is specifically required in California Regulations (1751.7(e)) and USP Chapter 797. Rationale: The definition of “batch” must be inserted into the regulatory requirements anywhere the term is used in order to determine its impact. The use of this definition creates problems in other parts of the proposed regulations. For example, 1751.4(d)(2) states that cleaning and disinfecting surfaces in the ISO Class 5 hood shall occur before and after each batch. If a batch is defined as two or more doses as described in 1735.1(b), pharmacy personnel would be required to perform hood cleaning up to several hundred times per day. The “Batch” definition from USP Chapter 797 applies only to “All high-risk level CSPs that are prepared in groups of more than 25 identical individual single-dose packages (e.g., ampules, bags, syringes, vials) or in multiple-dose vials (MDVs) for administration to multiple patients or that are exposed longer than 12 hours at 2 degrees C to 8 degrees C and longer than 6 hours at warmer than 8 degrees C before they are sterilized shall meet the sterility test (see Sterility Tests <71>) before they are dispensed or administered.”
1735.1(b)	California Society of Health-System Pharmacists Dawn Benton	Recommend defining “batch” as a quantity sufficient for sterility testing in high risk compounding preparations e.g. sterile from non-sterile ingredients, and quantities sufficient for testing sterility in the time period before required administration. Rationale: The definition of “batch” must be inserted into the regulatory requirements anywhere the term is used. As used in the proposed regulation the term would not be consistent with industry standards. e.g. USP 797 or the practice of pharmacy and would have substantial adverse impact on hospital efficiency, cost and timely therapy and thus also adversely affect patient safety and access to necessary medication therapy..

Code Section	Commenter	Comment
1735.1(b)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	Recommend modifying definition to: “batch means compounding, at any risk level, of two or more finished drug preparation units produced during the same continuous cycle of compounding and prepared in advance for patients yet to be identified
1735.1(b)	California Council for the Advancement of Pharmacy: Paige Talley, Management Consultant	Currently, USP <797> defines a batch as more than 25; and CCAP recommends that the board follows the USP <797> guidelines.
1735.1(b)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	USP 797 does not define a batch as two or more finished drug preparations. A batch size of more than 25 identical containers is the cutoff for additional testing (e.g. sterility and endotoxin) according the USP 797. This definition should be used instead in the regulations for consistency with USP 797.
1735.1(b)	Douglas Barcon, Pharm.D., Barcon & Associates	The definition of batch has been a point of contention for quite some time, and there are valid arguments with every definition. It is difficult to consider a batch to be two finished drug preparation units when a person is compounding two Zosyn 13.5 gram multi-dose infusions or continuous infusions for the same patient. Perhaps a batch should be more than two finished drug preparations units for one or more patients, as well as any multiple dose vials prepared for administration to more than one patient.
1735.1(b)	Harbor Compounding Pharmacy Mai Tran and Sam Kitahara	We recommend the definition of “batch” to be changed to: “Batch” means compounding of a preparation that is used for more than one patient (regardless of the number of finished drug preparation units) produced during the same continuous cycle of compounding.
1735.1(b)	Providence Heath & Services Southern California Region	"Batch" means compounding of finished drug products in groups of more than 25 units (optional:"or single-dose packages") produced during the same continuous cycle of compounding and shall include any multiple dos vials prepared for administration to more than one patient. The testing requirements under USP 797 for high-risk level CSPs apply only to batches of more than 25 units.
1735.1(c)	Harbor Compounding Pharmacy Mai Tran and Sam Kitahara	We recommend the definition of “beyond use date” to be changed to: “Beyond use date” means the date or date and time after which a compounded drug preparation shall not be dispensed or administered.
1735.1(d)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	This definition of a buffer area, along with the definition for segregated compounding area and designated compounding area only relates to the USP 797 cleanroom setting. In the non-USP 797 cleanroom setting, additional definitions are needed to define the compounding area, which is the ISO Class 5 laminar airflow hood. Without these additional definitions, there will be confusion in most hospital settings where ‘Satellite Pharmacies’ have an ISO 5 laminar airflow hood in a non-ISO room for ‘first doses’ to be administered immediately.

Code Section	Commenter	Comment
1735.1(e)	Harbor Compounding Pharmacy Mai Tran and Sam Kitahara	This is a confusing definition. Does this bulk drug definition apply to inactive ingredients such as bulk base creams and capsule fillers? This bulk drug definition is incorrect in that the bulk drug substance does NOT become an active ingredient in the dosage form of the drug. If so, we suggest changing the definition according to USP 795 guidelines: **Bulk Drug Substances**—Ingredients that are necessary to compound a preparation but are not intended or expected to cause a pharmacologic response if administered alone in the amount or concentration contained in a single dose of the compounded preparation.
1735.1(f)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend using the following definition for “cleanroom.” “Cleanroom means a separate room or area with or without walls and doors that provides at least an ISO Class 7 or better area where the primary engineering control is located. The cleanroom may maintain segregation from the adjacent ante-area by means of specific pressure differentials. For cleanrooms providing a physical separation through the use of walls, doors, and pass-through, a minimum differential positive pressure of 0.02- to 0.05-inch water column is required. For buffer areas not physically separated from the ante-areas, the principle of displacement airflow shall be employed. This concept utilizes a low pressure differential, high airflow principle. Using displacement airflow typically requires an air velocity of 40 ft per minute or more from the buffer area across the line of demarcation into the ante-area. The displacement concept shall not be used for high-risk compounding. Rationale: The industry standard, USP 797, does not describe the cleanroom as a physically separate room with walls and doors but can be separated through appropriate differentials in air flow from the “ante-areas.”

Code Section	Commenter	Comment
		~~(f) "C leanroom"(which may also be referred to as a buffer area) means a physically separate room with walls and doors providing at least an ISO Class 7 or better air quality where the primary engineering control is physically located. This room maintains segregation from the adjacent ante-area (ante-room) by means of specific pressure differentials. For rooms providing a physical separation through the use of walls, doors, and pass-throughs, a minimum differential positive pressure of 0.02- to 0.05-inch water column is required. For buffer areas not physically separated from the ante-areas, the principle of displacement airflow shall be employed. This concept utilizes a low pressure differential, high airflow principle. Using displacement airflow typically requires an air velocity of 40 ft per minute or more from the buffer area across the line of demarcation into the ante-area. The displacement concept shall not be used for high-risk compounding.~~
1735.1(f)	California Pharmacist Association Brian Warren	We recommend the following modification: (f) (1) "Compounding aseptic isolator " means a form of isolator specificall y designed for compounding drug preparations designed to maintain an aseptic compounding environment within the isolator throughout the compounding and material transfer process, with no air exchange into the isolator from the surrounding environment unless the air has first passed through a microbial retentive filter. (2) "Compounding aeptic containment isolator " means a form of compounding aseptic isolator designed to provide worker protection from exposure to undesirable levels of airborne drug throughout the compounding and material transfer process and to provide an aseptic environment for compounding sterile drug preparations, with no air exchange into or out of the isolator unless the air has first passed through a microbial retentive filter system capable of containing airborne concentrations of the physical size and state of the drug being compounded, and where the exhaust air from the isolator is appropriately removed by properly designed building ventilation when volatile hazardous drugs are compounded

Code Section	Commenter	Comment
1735.1(f)	Douglas Barcon, Pharm.D., Barcon & Associates	Consider pressure differentials for hazardous drug compounding in a negative pressure room within a cleanroom suite, which should be at least 0.01 inches negative pressure of water column relative to other surrounding controlled pressure rooms (per USP 800), including ISO Class 7 buffer rooms and ante rooms. Current proposed text states: Using displacement airflow typically requires an air velocity of 40 ft per minute or more from the buffer area across the line of demarcation into the ante-area. The displacement concept shall not be used for high-risk compounding. The proposed text does not state, as per USP 797 under Hazardous Drugs as CSPs, that hazardous drugs shall be prepared in a room that is physically separated from other preparation areas, and that the concept of airflow displacement shall not be used for hazardous drug compounding. Airflow displacement is not a physical separation. USP 800 also requires a separate area. Suggest changing the last sentence in the proposed text to read: "The displacement concept shall not be used for high-risk compounding or for hazardous drug compounding."
1735.1(f)	California Society of Health-System Pharmacists Dawn Benton	Recommend using the following definition for "cleanroom." "Cleanroom means a separate room or area with or without walls and doors that provides at least an ISO Class 7 or better area where the primary engineering control is located. The cleanroom may maintain segregation from the adjacent ante-area by means of specific pressure differentials. For cleanrooms providing a physical separation through the use of walls, doors, and pass-through, a minimum differential positive pressure of 0.02- to 0.05-inch water column is required. For buffer areas not physically separated from the ante-areas, the principle of displacement airflow shall be employed. This concept utilizes a low pressure differential, high airflow principle. Using displacement airflow typically requires an air velocity of 40 ft per minute or more from the buffer area across the line of demarcation into the ante-area. The displacement concept shall not be used for high-risk compounding. Rationale: USP 797 does not describe the cleanroom as a physically separate room with walls and doors but can be separated through appropriate differentials in airflow from the "ante-areas."
1735.1(f)	McGuff Compounding Pharmacy Services, Inc William J. Blair, Pharm.D., MBA Vice President and Director of Pharmacy Services	Comment: do not use a range to define a minimum number

Code Section	Commenter	Comment
1735.1(o)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend using the standard dictionary term of “parenteral” which means “other than by the enteral route”. It does not include only injections through the skin. Rationale: The new proposed definition is inconsistent with common usage and usage within the medical and pharmacy professions.
1735.1(g)	California Society of Health-System Pharmacists Dawn Benton	Recommend referencing USP N.F. 37-NF-32 for Section 1735.1 (g) though (i). Rationale: proposed regulation does not match industry standards as they evolve and is too specific for practical application
1735.1(g)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	Recommend use of current USP temperatures Of 2-8 degrees C. referencing USPN.F 37-NF-32
1735.1(g)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	There is conflict between how the BOP is proposing to define “controlled cold temperature” and how USP and CDC are defining it (2 degrees to 8 degrees C). Consider alignment of the proposed BOP definition with that of USP and CDC. As an alternative, consider including verbiage “The preparation may be stored at an alternate temperature range in accordance with the manufacturer’s recommendations or literature”. Concern the CSBOP may consider a facility noncompliant if a medication was stored at for example 2 degrees F despite the fact that the facility is storing the medication in accordance with the manufacturer’s recommendations or information in the literature.
1735.1(g)	McGuff Compounding Pharmacy Services, Inc William J. Blair, Pharm.D., MBA Vice President and Director of Pharmacy Services	Comment: Should use USP definition of “Controlled cold temperature” of 2 degrees to 8 degrees. No need for tenths which cannot be accurately measured on many thermometers.

Code Section	Commenter	Comment
1735.1(h)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	To determine if the proposed definition encompasses a range of compounded sterile products that require "freezer" temperatures would require a comprehensive review of the literature. Concerned that the proposed definition does not encompass the temperatures of commercially available medications stored in the freezer in accordance with the manufacturer recommendations that may be comingled with the compounded preparations. For example, cervidil vaginal inserts should be stored in the freezer between – 20 degrees C and – 10 degrees C, Baxter frozen premixed products must be stored at or below – 20 degrees C, Varivax© should be stored between –50 degrees C and –15 degrees C. Concern is that following the proposed "controlled freezer temperature" could lead to facilities storing medications in a freezer at a temperature that is not consistent with the manufacturer's recommendations or what is recommended in the literature in the case of a compounded medication. Consider adding the sentence "Medication preparations may be stored at an alternate temperature range in accordance with the manufacturer's recommendations or literature".
1735.1(i)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	The proposed definition encompasses the usual and customary working environment of 20 degrees to 25 degrees C (68 degrees to 77 degrees F) but USP General Notice 10.30.40 allows for transient excursions between 15 degrees C and 30 degrees C (59 degrees to 86 degrees F). Consider aligning with the USP General Notice.
1735.1(k)	Community Regional Medical Center Bruce Lepley, Director of Pharmacy	Reason for Concern: The definition is not used in the body of the proposed regulations. If the definition is not used this may lead to confusion by leaving it in the definition section. Solution: Remove section that defines "first air" altogether
1735.1(o)	California Society of Health-System Pharmacists Dawn Benton	Recommend using the dictionary definition of parenteral that means "other than by the enteral route". Rationale: the proposed definition is inconsistent with statutory language and common usage.
1735.1(o)	Providence Heath & Services Southern California Region	"Parenteral means a ~~sterile~~ preparation of drugs ~~for injection or implantation through one or more layers of skin~~ to be administered in a manner other than through the digestive tract. This includes, but is not limited to, injection through one or more layers of skin, administration into the eye and by inhalation. Providence recommends that the regulatory definition should be consistent with medical definition of "parenteral" and SB 294 [Article 7.5, Sec 3. 4127(a)].
1735.1(q)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	Recommend eliminating potency testing requirements for the following three scenarios: 1. A compounded drug product where the full prepared quantity will be delivered in the original diluent contained in Manufacturer produced overfill 2. Manufacturer written communication (PI, Letter, email) stating that a particular prep has been tested 3. Scientific article from refereed journal identifying stability
1735.1(q)	Sutter Health Jeannette Hanni	Recommend adding an exemption for any compounded drug product where the full, prepared quantity will be delivered and the original diluent contained a manufacturer produced "overfill".

Code Section	Commenter	Comment
1735.1(q)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	An ISO class 5 laminar airflow hood in and of itself should meet the requirements of this definition. The addition of a 3 foot demarcated area surrounding the ISO5 laminar airflow hood may eliminate the possibility of compounding in an existing satellite pharmacy. USP 797 does not include the 3 foot perimeter demarcation in the definition of a segregated compounding area and it should be removed from the Board's definition. Keeping this definition may exclude compounding areas already built and in use for sterile compounding. If the ISO Class 5 laminar airflow hood meets this definition of a 'segregated compounding area', the remainder of the regulation must be edited to account for this fact. The compounding area of this kind of laminar airflow hood is a 'designated space that is restricted to preparing sterile-to-sterile compounding'. If this regulation is not edited to include the practices occurring in a Pharmacy Satellite (non-USP 797 cleanroom area) compounding of sterile products will once again revert to being done by nursing staff in the medication room, as it is not possible with a centrally located IV room to respond to the immediate needs of ICU patients for compounded drips and first dose sterile products for all other patients. Under the pressure of timeliness, the preparation of sterile products will once again become the purview of the nursing staff. <u>This is not to be viewed as a step forward for medication safety. It will increase wastage and will result in movement of preparations to the bedside by nursing which is a less safe practice than current pharmacy standard clinical practice around sterile compounding</u>.
1735.1(t)	Douglas Barcon, Pharm.D., Barcon & Associates	Add at end "for the exposure of critical sites when compounding sterile preparations," in order to bring closer to the definition of PEC in USP 797 while also matching board of pharmacy terminology.
1735.1(t)	Harbor Compounding Pharmacy Mai Tran and Sam Kitahara	We want to make sure that the definition of a PEC means specifically for devices that are used in the compounding of compounded sterile preparations. We suggest changing to "Primary Engineering Control" means a device that provides an ISO Class 5 environment or better through the use of unidirectional HEPA filtered first air <u>when compounding compounded sterile preparations.</u>
1735.1(w)	Harbor Compounding Pharmacy Mai Tran and Sam Kitahara	Current labeling guidelines for non-sterile compounded preparations do not require the labeling of inactive ingredients on the label (only the active pharmaceutical ingredient). If so, then the definition of quality is not applicable since if the compounded non-sterile preparation contains inactive ingredient "glycerin," and if the label says it is Progesterone 200mg/ml cream, then according to the proposed definition of quality, because the label only lists progesterone and does not list glycerin, then this is of subpar quality because the progesterone cream contains glycerin when it's not supposed to. We suggest changing the definition to eliminate the word inactive ingredients: "Quality" means the absence of harmful levels of contaminants, including filth, putrid, or decomposed substances, and absence of active ingredients other than those noted on the label.

Code Section	Commenter	Comment
1735.1(x)	GrayMatter Pharmacy Services, Inc Michael Moore, R.Ph.	What is a three foot perimeter? Do you mean that the demarcated area needs to extend three feet in all directions from the isolator? Three feet from the opening? I believe I have spoken before about the problems small hospitals have with compliance on this issue. Requiring additional space will make compliance more difficult for small pharmacies. "…Such area shall contain and shall be void of activities and materials…" I cannot understand this phrase. It is a contradiction to both "contain" and "be void of".
1735.1(x)	Sutter Health Jeannette Hanni	Recommend adding a definition of "adjacent" in order to allow for hospital construction. Recommend adding a definition of "warehouse" in order to differentiate it from a pharmacy that may be built in a building constructed as a warehouse.
1735.1(x)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Concern: The definition is overly complex and is not in concordance with USP Chapter 797 Recommendation: Use the definition of Segregated Compounding Area in USP Chapter 797: A designated space, either a demarcated area or room, that is restricted to preparing low-risk level CSPs with 12-hour or less BUD. Such area shall contain a device that provides unidirectional airflow of ISO Class 5 air quality for preparation of CSPs and shall be void of activities and materials that are extraneous to sterile compounding.
1735.1(x)	Douglas Barcon, Pharm.D., Barcon & Associates	**Such area shall contain and shall be void of activities and materials that are extraneous to sterile compounding.** Confusing sentence in bold. Consider deleting "shall contain and." Alternatively, could add "not" between "shall" and "contain." Does adjacent include a warehouse in the unit next to a home infusion pharmacy that has a cleanroom and a segregated compounding area, where the businesses share a common wall between units? If there was no warehouse in the next unit when the cleanroom or segregated compounding area was installed but a warehouse was installed later by the new lessee, the pharmacy should not be expected to move the cleanroom or segregated compounding area. Perhaps a segregated compounding area should be specifically limited to hospitals and perhaps also skilled nursing facilities.
1735.1(y)	Sutter Health Jeannette Hanni	Recommend removal of the smoke test definition as it is not used or referenced throughout the regulation.
1735.1(y)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend removal of the "smoke test" definition. Rationale: Vague and confusing as proposed – The term is not used or referenced throughout the regulation; not industry standard. Further, the use of a "smoke test" in a hospital environment on patient floors in the drug rooms (aka "satellites" that the Board of Pharmacy requires to have a separate Sterile Compounding License has not been evaluated for patient safety and impact on the patient care environment.

Code Section	Commenter	Comment
1735.1(y)	California Society of Health-System Pharmacists Dawn Benton	Recommend removal of the smoke test definition. Rationale: Vague and confusing as proposed - not used or referenced throughout the regulation; not industry standard.
1735.1(y)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	Recommend removal of the smoke test definition as it is not used or referenced throughout the regulation.
1735.1(y)	Providence Heath & Services Southern California Region	~~"Smoke test" means an analysis of the airflow in the ISO Class 5 PEC using a smoke generating device.~~ **Providence recommends removal of the smoke test definition as it is not used or referenced throughout the regulation.**
1735.2	Unknown Speaker at Hearing	Conflicts with 1751.8 beyond use dates. Clarification required on whether judgment of pharmacist supersedes 1751.8 limits
1735.2	San Mateo Medical Center Gary L. Horne, Director of Pharmacy	Consider adding language such as *"Exempt from the requirements in this paragraph are sterile preparations compounded on* ***a one-time basis for administration*** *within seventy-two {72} hours to an inpatient in a health care facility licensed under section 1250 of the Health and Safety Code and stored in accordance with standards for "Redispensed CSPs" found in Chapter 797 of the United States Pharmacopeia- National Formulary {USP37-NF32} Through 2nd Supplement {37th Revision, Effective December 1, 2014), hereby incorporated by reference.*
1735.2(a)	Central Admixture Pharmacy Services, Inc William Jones	Change the wording in (a) to read: Except as specified in (b), (c), or (d) no drug product preparation shall be compounded …. Insert a new section (d) to read: "The pharmacy is a 503B FDA registered Outsourcing Facility."
1735.2(b)	The Institute for Community Pharmacy John Cronin	**(1)** A pharmacy may prepare and store a limited quantity of a compounded drug product preparation in advance of receipt of a patient-specific prescription where and solely in such quantity as is necessary to ensure continuity of care for an identified population of patients of the pharmacy based on a documented history of prescriptions for that patient population. **Add: (2) A pharmacy may compound preparations without the valid prescription for an individual patient required by subsection (a) for the purposes of clinical research that complies with requirements of the federal Food and Drug Administration (FDA).** ICP encourages the Board to deal with the issue of compounding for the purpose of clinical research. We believe the suggested language addresses this issue. However, our primary objective in making this suggestion is to have the Board resolve an issue that is not currently addressed in California law.

Code Section	Commenter	Comment
1735.2(c)(1)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Omit in sub-section 1735.2(c)(1) the requirement that the order "that lists the number of patients 'seen' or 'to be seen' and the "quantity for each patient" and replace it with a requirement for an "estimate" of that information, instead of placing the phrase "as estimated by the prescriber" at the end of the sub-section. Rationale: Saying first that the order must "list the number" and "quantity for each patient" and then saying it may be estimated adds to the confusion of what is required.
1735.2(c)(1)	McGuff Compounding Pharmacy Services, Inc William J. Blair, Pharm.D., MBA Vice President and Director of Pharmacy Services	Comment: Listing the number of patients would require a prescriber to utilize his/her best guess. We do not see any added value to the prescriber, patient or pharmacy as the prescribers order is already his best guess for the future. We would anticipate the "number of patients to seen or to be seen" would always match the doses ordered.
1735.2(c)(1)	Harbor Compounding Pharmacy Mai Tran and Sam Kitahara	Is order by the prescriber or his/her representative, and paid for by the prescriber
1735.2(c)(1)	California Council for the Advancement of Pharmacy: Paige Talley, Management Consultant	The requirement of the pharmacy to be furnished a list of the number of patients to be seen is unreasonable when the number of patients may be inferred by the number of doses provided to the physician for a 72-hour period. CCAP recommends that the Board of Pharmacy removes that requirement from the proposed regulations.
1735.2(c)(2)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: Replace sub-section 1735.2(c)(2) with "is delivered to the prescriber's office and signed for by the prescriber or prescriber's agent," Rationale: The prescriber signature requirement is impractical and overly burdensome. In an office practice, the prescriber is not always immediately available. It is common for nurses and medical assistants to receive supplies and medications on behalf of physicians and other prescribers.
1735.2(c)(2)	California Society of Health-System Pharmacists Dawn Benton	Recommend deleting "is delivered to the prescriber office" and adding "or their agent". Rationale: the requirement for a physician or other prescriber to personally sign for the receipt of compounded products is beyond the scope of authority of the Board of Pharmacy and the ability of pharmacists to enforce thus potentially denying patients access to the safety of pharmacist compounded preparations. The ability of physicians and other prescribers to function through authorized agents is clearly established under California law.

Code Section	Commenter	Comment
1735.2(c)(2)	California Pharmacist Association Brian Warren	We recommend the following modification to Section 1735.2 (c)(2): (2) is delivered to the prescriber office and signed for by the prescriber or the prescriber's agent.
1735.2(c)(2)	Harbor Compounding Pharmacy Mai Tran and Sam Kitahara	Is delivered to the prescriber office and signed for by the prescriber or his/her representative
1735.2(c)(2)	McGuff Compounding Pharmacy Services, Inc William J. Blair, Pharm.D., MBA Vice President and Director of Pharmacy Services	Comment: This assumes a prescriber is always available in an "office" when a delivery takes place. Delivery of compounded drugs from different sources, different delivery companies, at random delivery times would unnecessarily restrict prescriber to his/her office, take the prescriber away from professional duties to see patients. A compounded drug is a prescription drug the same as a commercially available drug. Commercially available drugs do not have this signature requirement. Why create a difference? Receipt of drugs and devices can and should be delegated.
1735.2(c)(2)	California Council for the Advancement of Pharmacy: Paige Talley, Management Consultant	Given that the prescriber is not always in his/her office, it would be more efficient to require that the prescriber or the prescriber's agent or authorized licensed staff sign for the delivery of compounded medications.
1735.2(d)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: Define this term in 1735.1, as an exact copy of a commercially-available drug (exact same chemical entity, dose, volume, diluent) so that interpretation issues do not arise regarding the definition. Rationale: The meaning of this language is unclear. Does "copy" mean the exact drug product? A generic version of a branded drug? A therapeutic substitution of a drug?
1735.2(d)(3)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: Replace "ASHP" with "industry standard drug shortage list." Also, we recommend adding language to address drugs not yet placed on a national or State shortage list but actually in short supply at the patient care level. Rationale: exclusive reliance on ASHP or the FDA shortage lists does not recognize the common existence of local product shortages and the delay in inclusion of shortage products on those lists.
1735.2(d)(3)	California Society of Health-System Pharmacists Dawn Benton	Recommend replacing "ASHP" with "industry standard drug shortage list." Recommend adding language to address drugs not yet placed on a shortage list. Rationale: exclusive reliance on ASHP or the FDA shortage lists does not recognize the common existence of local product shortages and the delay in inclusion of shortage products on those lists.

Code Section	Commenter	Comment
1735.2(d)(3)	McGuff Compounding Pharmacy Services, Inc William J. Blair, Pharm.D., MBA Vice President and Director of Pharmacy Services	Comment: Currently, the FDA does not monitor end users or wholesalers for drug shortages. FDA relies upon manufacture's statements that a drug is no longer on shortage. Patients need these drugs compounded when they are not available. In addition, remove "at the time of dispense" as any drug compounded, in limited quantities, in good faith during the shortage should be allowed to be dispensed.
1735.2(d)(3)	California Council for the Advancement of Pharmacy: Paige Talley, Management Consultant	There is concern that if a manufacturer has not conveyed to the FDA that there is a drug shortage, the drug in question will not be on the FDA list of drugs in short supply. Please include manufacturer availability.
1735.2(d)(3)	Gary Horne: Hearing Testimony San Mateo Medical Center	Cannot compound sterile product that is commerically available. Exempt products for one time use for administration within 72 hrs for inpatient.
1735.2(d)(3)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Many drug shortages that impact facilities do not appear on the "ASHP or FDA list of drugs that are in short supply". The medication in "short supply" may be a temporary supply interruption that impacts a region or a single facility in which case it may not appear or there may be a considerable delay in appearing on the ASHP or FDA list of drugs that are in short supply. Consider softening the language so as not to insert an unnecessary and potentially unsafe barrier to patients receiving a critically needed medication. In addition, consider deleting the verbiage "at the time of dispense". If a medication has been compounded after determining the preparation meets the requirements of this section, allow it's dispensing up until the beyond use date. It would be a waste of precious drug resources to not permit use of a compounded preparation that is still suitable for use but is no longer on the ASHP or FDA list.
1735.2(e)	Gary Horne: Hearing Testimony San Mateo Medical Center	Record keeping burden to list master formula for products that are purchased

Code Section	Commenter	Comment
1735.2(e)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: Add a requirement for the Master Formula to contain as section on "End-Product Examination Criteria" Rationale: Regulation Section 1735, et seq. apply to all types of Pharmacy Compounding, non-sterile and sterile. Each type of preparation has criteria that should be used for the compounding pharmacist to determine the end-products appropriateness and consistency with previous preparations compounded using the same Master Formula.
1735.2(e)	Harbor Compounding Pharmacy Mai Tran and Sam Kitahara	A drug preparation shall not be compounded until the pharmacy has first prepared a written or electronic master formula record that includes at least the following elements
1735.2(g)	Community Regional Medical Center Bruce Lepley, Director of Pharmacy	Reason for Concern: For hospital pharmacies using only sterile FDA approved products for compounded sterile products we are ensuring that the product contains the appropriate amount of active ingredient. In addition, we are not successful in finding any laboratories in our area that can assay products to determine the amount (e.g. milligrams) of active ingredient in a compounded sterile product. Many laboratories use liquid chromatography-mass spectrometry (LCMS) that uses mass analysis and physical separation techniques to determine if a substance displays the same LCMS properties as a reference compound. This assay does not determine for instance a milligram amount of a substance in a compounded product so it would not meet the proposed regulation. Solution: Remove "potency" from the "integrity" definition and remove the requirement of the pharmacy determining, maintaining, validating and monitoring potency for compounded products if the source of the CSP's come from sterile FDA approved products.
1735.2(f)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Rewording the regulation to use the word "frequency" instead of "routinely". as follows: "Where a pharmacy does not frequently compound a particular drug product preparation, the master formula record for that product preparation may be recorded on the prescription document itself or as appropriate for hospital practice, or in an electronic database.". Rationale: to clarify the application of this provision in hospitals and for preparations for administration in clinics and medical offices where prescription documents are not used for hospitalized and clinic or medical office patients. Changing "routinely" to "frequently" clarifies the intent is to promote consistency.

Code Section	Commenter	Comment
1735.2(f)	California Society of Health-System Pharmacists Dawn Benton	Recommend rewording this provision as follows: Where a pharmacy does not frequently compound a particular drug product preparation, the master formula record for that product preparation may be recorded on the prescription document itself or as appropriate for hospital practice, or in an electronic database. Rationale: to clarify the application of this provision in hospitals and for preparations for administration in clinics and medical offices where prescription documents are not used for hospitalized and clinic or medical office patients. Changing routinely to frequently to clarify the frequency.
1735.2(i)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Concern: The proposed wording “it should not be used” is ambiguous and not in concordance with USP Chapter 797 If this definition remains as written, it could be interpreted that the administration of a preparation should be stopped prior to completion, if the BUD is reached. This is not the intent of the BUD, and may lead to excessive changes/manipulations of preparations and an increased risk of harm. For example, a pharmacy could prepare 5-Fluorocuracil (5-FU), a cancer chemotherapy drug, for intravenous administration to a patient using a portable infusion pump in the home setting. 5-FU has a 30-hour beyond use date, and is infused over a period of 46 hours from a single drug container. If the proposed language is not changed, the beyond use date would be reached in the midst of the infusion; requiring that the infusion be stopped and the existing 5-FU drug container replaced with a new one. This would create the risk of error and possible infection. Recommendation: Change to the language proposed in 1735.1(c): “Beyond use date” means the date or date and time after which a compounded drug preparation shall not be stored or transported, or administration begun.
1735.2(i)	Harbor Compounding Pharmacy Mai Tran and Sam Kitahara	Every compounded drug preparation shall be given a beyond-use date representing the date beyond which, in the professional judgment of the pharmacy performing or supervising the compounding, it should not <u>BE DISPENSED OR ADMINISTERED.</u>
1735.3	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	While this may be applicable for compounding within a USP 797 compliant cleanroom, it is impossible and unnecessary to comply with this in a Pharmacy Satellite environment (non USP 797 compliant cleanroom) for first dose sterile to sterile compounding. The regulation as well as others within this proposal needs to be adjusted to allow for two kinds of hospital based compounding (satellite and central USP 797 cleanroom compounding). Otherwise this too will force intravenous medication preparation from the pharmacy to nursing at the bedside. What is the definition of a one-time basis? <u>Clarification is needed so there is no ambiguity</u>.
1735.3	San Mateo Medical Center Gary L. Horne, Director of Pharmacy	The following statement should apply to all paragraphs/sections of (a) {1) through (10)."Exempt from the requirements in this paragraph **are sterile preparations** compounded on a one-time basis for administration within seventy-two (72) hours to an inpatient in a health care facility licensed under section 1250 of the Health and Safety Code and stored in accordance with **standards for "Redispensed CSPs"** found in Chapter 797 of the United States Pharmacopeia- National Formulary (USP37-NF32) Through 2nd Supplement {37th Revision, Effective December 1, 2014), hereby incorporated by reference.

Code Section	Commenter	Comment
1735.3(a)(1)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend changing 1735.3 (a) (1) to read: "A reference to the applicable version of the master formula." Rationale: for consistency, master formula documentation is often maintained centrally in electronic records or locally in bound volumes. Requiring duplication on the compounding record is unnecessary. A master formula may be changed periodically and the compounding record should reference the version used for that particular preparation
1735.3(a)(1)	California Society of Health-System Pharmacists Dawn Benton	Recommend changing 1735.3 (a) (1) to read: "A reference to the applicable version of the master formula." Rationale: for consistency, master formula documentation is often maintained centrally in electronic records or locally in bound volumes. Requiring duplication on the compounding record is unnecessary.
1735.3(a)(6)	Cedars-Sinai Katherine Palmer Rita Shane	Recommended changes are to ensure consistency with beyond use dating specified in 1751.8 (p32). Additionally,USP 797 does not require this documentation for low and medium risk sterile to sterile preparations
1735.3(a)(10)	Sutter Health Jeannette Hanni	Recommend removing the documentation for storage of the drug preparation from 1735.3(a)(10) and adding this to section 1735.2(e) to be included as a requirement for the master formula record for the drug preparation Storage requirements for the compounded drug preparation should be consistent each time it is compounded or batch prepared and included in the master formula record.
1735.3(a)(10)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend removing the documentation for storage of the drug preparation from 1735.3(a)(10) and adding this to section 1735.2(e) to be included as a requirement for the master formula record for the drug preparation. Rationale: Storage requirements for the compounded drug preparation should be consistent each time it is compounded or batch prepared and included in the master formula.
1735.3(a)(10)	California Society of Health-System Pharmacists Dawn Benton	Recommend removing the documentation for storage of the drug preparation from 1735.3(a)(10) and adding this to section 1735.2(e) to be included as a requirement for the master formula record for the drug preparation. Rationale: Storage requirements for the compounded drug preparation should be consistent each time it is compounded or batch prepared and included in the master formula.
1735.3(a)(10)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	Recommend removing the documentation for storage of the drug preparation from 1735.3(a)(10) and adding this to section 1735.2(e) to be included as a requirement for the master formula record for the drug preparation. Storage requirements for the compounded drug preparation should be compounded or batch prepared and included in the master formula record
1735.3(a)(10)	Providence Heath & Services Southern California Region	Providence recommends removing the documentation for storage of the drug preparation from 1735.3(a)(10) and adding this to section 1735.2(e) to be included as a requirement for the master formula record for the drug preparation. Storage requirements for the compounded drug preparation should be consistent each time it is compounded or batch prepared and included in the master formula record.

Code Section	Commenter	Comment
1735.3(c)	California Society of Health-System Pharmacists Dawn Benton	Recommend changing “FDA registered supplier” to “reliable supplier.” Rationale: Many ingredients, including pharmaceutical ingredients, are not registered with the FDA. For example, many OTC ingredients.
1735.3(c)	California Pharmacist Association Brian Warren	The proposed changes to Section 1735.3, relating to recordkeeping, among other things, require suppliers of chemicals, bulk drug substances, and drug products to be FDA-registered, and strike an existing provision in subdivision (c) that states “certificates of purity or analysis are not required for drug products that are approved by the Food and Drug Administration.” We believe that this sentence should not be stricken from subdivision (c). The Board has stated that this change is necessary to “ensure that the supplier of drug products are adequately regulated by the Food and Drug Administration (FDA) and addressed the problem of the integrity of the purchased drug products by compounders providing compounded drug products to California consumers,” and to “ensure a consolidated record for a compounded drug product that may have multiple ingredients from multiple FDA-registered suppliers.” However, for drug products approved by the FDA, the FDA is the regulator of those products and responsible for ensuring that manufacturers ensure their products meet specification. (c) Active pharmaceutical ingredients shall be obtained from a FDA registered supplier. All other chemicals, bulk drug substances, and drug products, and components used to compound drug products preparations shall be obtained, whenever possible, from reliable FDA-registered suppliers. The pharmacy shall acquire and retain any available certificates of purity or analysis for chemicals, and bulk drug substances, drug products, and components used in compounding. **Certificates of purity or analysis are not required for drug products that are approved by the Food and Drug Administration**. Certificate s of purity or analysis are not required for drug products that are approved by the Food and Drug Administration. Certificates of purity or analysis, if available, are to be matched to the product received.
1735.4	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	Is this applicable for IV solution labels compounded for inpatients?
1735.4(a)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend revising to be consistent with recent discussions by the Board regarding B&P code 4076). Rationale: Labeling with trade names has been identified as a safety factor for prescription labels to prevent duplication of therapy and other adverse events.
1735.4(a)	California Society of Health-System Pharmacists Dawn Benton	Recommend revising to be consisted with recent discussions by the Board regarding B&P code 4076). Rationale: Labeling with trade names has been identified as a safety factor for prescription labels to prevent duplication of therapy and other adverse events.

Code Section	Commenter	Comment
1735.4(a)	San Mateo Medical Center Gary L. Horne, Director of Pharmacy	Consider changing generic to either brand or generic. This is because some hospital pharmacy systems may use the brand name of drug products for clarity for the nursing staff who will be asministering CSP.
1735.4(b)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend deleting “or on the receipt”. Rationale: Since this provision only applies to what is provided to the PATIENT (or patient’s representative” ,for consistency with consumer and provider concern about knowing whether a compounded preparation is FDA approved, the statement should be provided on the label. The patient or provider may never see a receipt.
1735.4(b)	California Society of Health-System Pharmacists Dawn Benton	Recommend deleting “or on the receipt”. Rationale: Consistency with consumer concern about knowing whether a compounded preparation is FDA approved.
1735.4(b)	San Mateo Medical Center Gary L. Horne, Director of Pharmacy	Exempt from the requirements in this paragraph are sterile preparations compounded on a one-time basis for administration within seventy-two (72) hours to an inpatient in a health care facility licensed under section 1250 of the Health and Safety Code and stored in accordance with standards for "Redispensed CSPs" found in Chapter 797 of the United States Pharmacopeia- National Formulary (USP37-NF32) Through 2nd Supplement {37th Revision, Effective December 1, 2014), hereby incorporated by reference.
1735.4(b)	GrayMatter Pharmacy Services, Inc Michael Moore, R.Ph.	This section should be modified to exclude compounded sterile products prepared by inpatient pharmacies. Once again we see another discrepancy between what should happen with “compounding pharmacies” and in-patient hospital pharmacies. This is too broad a brush to paint the whole industry and inspectors are not following the spirit of this intended language.
1735.4(c)	Sutter Health Jeannette Hanni	Recommend adding, "if the container is too small to add the facility label, the facility label may be placed on the overwrap"
1735.4(c)	California Society of Health-System Pharmacists Dawn Benton	Recommend adding “if the container is too small to add the facility label, the facility label may be placed on the overwrap.” Rationale: To accommodate unit dose and other small packages of compounded products.
1735.4(c)	California Pharmacist Association Brian Warren	We recommend the following modification to Section 1735.4 (c): Add: Drug preparations compounded into unit-dose containers that are too small for full compliance with subdivisions (a) and (b) are exempt from any minimum font size requirements in this Division.
1735.4(c)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	Recommend adding”, if the container is too small to add the facility label, the facility label may be placed on the overwrap”

Code Section	Commenter	Comment
1735.4(c)	San Mateo Medical Center Gary L. Horne, Director of Pharmacy	Exempt from the requirements in this paragraph are sterile preparations compounded on a one-time basis for administration within seventy-two (72) hours to an inpatient in a health care facility licensed under section 1250 of the Health and Safety Code and stored in accordance with standards for "Redispensed CSPs" found in Chapter 797 of the United States Pharmacopeia- National Formulary (USP37-NF32) Through 2nd Supplement {37th Revision, Effective December 1, 2014), hereby incorporated by reference.
1735.5	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	The policy and procedure requirements are in two sections of the regulations each having some of the same requirements and some different. It makes it extremely difficult to understand and comply with all aspects when they are found in different locations in the law
1735.5	Douglas Barcon, Pharm.D., Barcon & Associates	Suggest adding new paragraph after (c) (11): (12) Policies and procedures regarding ensuring appropriate relative humidity in the compounding areas for sterile injectable preparations, and actions to take regarding any out of range relative humidity variations.
1735.5(a)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	*The Pharmacy shall follow its policies and procedures. Failure to follow these policies and procedures shall constitute grounds for disciplinary action.* Comment regarding section underlined: Thank you for reviewing and considering the feedback provided for the previous proposed revisions to 1735.5(a). Modification of the previously proposed changes “failure to follow these policies and procedures shall be deemed unprofessional conduct” to what is being proposed “Failure to follow these policies and procedures shall constitute grounds for disciplinary action.” is a much appreciated step in the right direction. Please consider further modification to adopt language that is more in line with ”Just Culture”. This would benefit patient safety by encouraging a strong culture of safety. Currently proposed changes do not provide latitude for minor policy and procedure deviations; which bear no reasonable risks to the patient. If approved as proposed, there may be unintended consequences such as reduced error reporting and creation of policy and procedures that are not specific enough to guide preparation or other aspects of compounding.
1735.5(c)(2)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Considering clarifying in a FAQ or revising the language. Many facilities maintain “evidence of staff education and training” in a staff competency file or in employees individual personnel record and not actually in the policy and procedures manual. Would it be permitted to have a policy in your manual that references there must be evidence of education and training, and where that evidence is located?
1735.5(c)(4)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	There is a problem with doing this for one time first dose sterile to sterile compounding. There is no way to validate these products by this definition since the product is made and used on the patient and therefore is not available for validation. This illustrates a problem with the regulations as the statements often are only applicable to compounding pharmacies that are compounding batches – not to hospital pharmacies that are compounding a single product for a patient. The regulations should be separated into two distinct sections – one for compounding pharmacies and one for hospital pharmacies.

Code Section	Commenter	Comment
1735.5(c)(6)	Community Regional Medical Center Bruce Lepley, Director of Pharmacy	Reason for Concern: For hospital pharmacies using only sterile FDA approved products for compounded sterile products we are ensuring that the product contains the appropriate amount of active ingredient. In addition, we are not successful in finding any laboratories in our area that can assay products to determine the amount (e.g. milligrams) of active ingredient in a compounded sterile product. Many laboratories use liquid chromatography-mass spectrometry (LCMS) that uses mass analysis and physical separation techniques to determine if a substance displays the same LCMS properties as a reference compound. This assay does not determine for instance a milligram amount of a substance in a compounded product so it would not meet the proposed regulation. Solution: Remove “potency” from the “integrity” definition and remove the requirement of the pharmacy determining, maintaining, validating and monitoring potency for compounded products if the source of the CSP’s come from sterile FDA approved products.
1735.5(c)(8)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	Recommend additional language at end after “pharmacist-in-charge” “or other evidence that each policy and procedure has been reviewed annually.”
1735.5(c)(8)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend editing to read “Dates of annual reviews of the policy and procedure manual by the pharmacist-in-charge, signed and dated by the pharmacist-in-charge or other evidence that each policy and procedure has been reviewed annually.”. Rationale: Records of policy and procedure review and modification are often kept electronically to facilitate access by all pharmacy personnel and accreditation and regulatory surveyors.
1735.5(c)(8)	Sutter Health Jeannette Hanni	Recommend additional language: "...by the pharmacist in charge or other evidence that each policy and procedure has been reviewed annually.
1735.5(c)(8)	California Society of Health-System Pharmacists Dawn Benton	Recommend editing (8) to read “Dates of annual reviews of the policy and procedure manual by the pharmacist-in-charge, signed and dated by the pharmacist-in-charge or other evidence that each policy and procedure has been reviewed annually.” Rationale: Records of policy and procedure review and modification are often kept electronically to facilitate access by all pharmacy personnel and accreditation and regulatory surveyors.
1735.5(c)(10)	California Society of Health-System Pharmacists Dawn Benton	Recommend adding “in the pharmacy” at the very end. Would read: “Policies and procedures for storage of compounded sterile drug preparations in the pharmacy and daily documentation of all room, refrigerator, and freezer temperatures in the pharmacy.” Rationale: To clarify which refrigerators to mean only those in the pharmacy.
1735.5(c)(10)	Sutter Health Jeannette Hanni	Recommend adding the qualifying language from USP 797 to consistently align with the national standards.

Code Section	Commenter	Comment
1735.5(c)(10)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	1. Recommend adding "in the pharmacy" at the very end. Would read: "Policies and procedures for storage of compounded sterile drug preparations in the pharmacy and daily documentation of all room, refrigerator, and freezer temperatures in the pharmacy." Rationale: To clarify which refrigerators to mean only those in the pharmacy. 2. Recommendation: Add language that supports the use of methods other than daily logs. "Policies and procedures for storage of compounded sterile drug preparations in the pharmacy and daily documentation of room, refrigerator, and freezer temperatures, through the use of paper logs or continuous temperature monitoring devices with appropriate alarms/alerts. Rationale: This language, particularly the phrase "daily documentation" could be interpreted to mean that only paper logs would be acceptable. Continuous electronic monitoring technology is at least as good as, if not superior to, manual documentation on paper logs
1735.5(c)(10)	Douglas Barcon, Pharm.D., Barcon & Associates	After temperatures, delete the period and add "; and relative humidity in the compounding areas." Relative humidity is specified in 1751.3 (d)(3)(L) and 1751.4 (j).
1735.5(c)(10)	Providence Heath & Services Southern California Region 20555 Earl Street Torrance, CA 90503	Policies and procedures for storage of compounded sterile drug preparations in the pharmacy and daily documentation of all room, refrigerator, and freezer temperatures. If the compounding facility uses a continuous temperature recording device, compounding personnel shall verify at least once daily that the recording device itself is functioning properly. Providence recommends adding the qualifying language from USP 797 to consistently align with the national standards. Our refrigeration units provide continuous temperature monitoring and alert systems. Daily documentation would not provide an advantage to this 24/7monitoring nor does it increase patient safety beyond the systems already in place.
1735.6(c)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Consider deleting the words "in writing". This will allow pharmacies to maintain their records electronically if they choose. In addition, our automated compounding device (BAXA EM 2400) requires calibration; which once completed, generates a printed report of the calibration. Would this documentation be considered a record of calibration "in writing"?
1735.7(a)	The Institute for Community Pharmacy John Cronin	Any pharmacy engaged in compounding shall maintain written documentation sufficient to demonstrate that pharmacy personnel have the skills and training required to properly and accurately perform their assigned responsibilities relating to compounding. **"Training" as used in this subsection may include practice experience in the types of compounding in which the pharmacy personnel will be involved.**

Code Section	Commenter	Comment
1735.8	San Mateo Medical Center Gary L. Horne, Director of Pharmacy	The language in this section is problematic in that the interpretation has been that any and all compounded products must be tested for "integrity, and ensure the integrity, potency, quality, and labeled strength". While this is a requirement for manufacturing, unless the pharmacy is compounding batches intended for future use, the actual testing for integrity, potency, quality, and labeled strength for every preparation compounded by the pharmacy creates not only operational and financial burdens, there is no scientific rationale. If a pharmacy routinely compounds a non-sterile product for immediate dispensing or, such as in a hospital, the pharmacy compounds sterile products for immediate use, testing samples of these products will only provide the results for that one preparation. In other words, if you test one sample, you know the results of one sample. Also, there are many compounded products (sterile and non-sterile) for which no laboratory test exists. It is clear that having policies, procedures, training and competency assessment to validate and ensure that personnel involved in compounding are competent to do so is the appropriate method to ensure the integrity, potency, quality, and labeled strength of compounded drug preparations. The existing and proposed language intentionally omits "laboratory testing is required for all products" because the intent of the regulations was to have proper policies, procedures, training and competency assessment to validate and ensure that personnel involved in compounding are competent. Furthermore, it is the process validation that ensures the integrity of the product.
1735.8	GrayMatter Pharmacy Services, Inc Michael Moore, R.Ph.	While much of this section remains unchanged, I have concerns about creating such a vague requirement to monitor quantitative accuracy. I believe that this section should be approached from two different perspectives. 1) From the perspective of the facility – a facility should show that its equipment is working appropriately and accurately. For example, if I am using a TPN compounder and a batch pump samples should be made to ensure that these pieces of equipment are working according to expectation. 2) more importantly – individuals compounding should be performing their activities accurately as well. We have a requirement to validate aseptic technique but no requirement exists to substantiate competence at quantitative compounding. If the board believes this should be monitored, then a specific requirement should be listed in the regulations. “Minimum standards” should be spelled out as well. We need guidance for what will be acceptable to the board with consistency. I don’t want one inspect to come in and tell me 10% error is acceptable only to have another inspector the following year tell me it needs to be 5%. With all this said, I find it difficult to find a need for this section of the regulations. At most I might be able to understand the need for #1 above (facility testing).

Code Section	Commenter	Comment
1735.8(a) and (c) and (d)	Community Regional Medical Center Bruce Lepley, Director of Pharmacy	Reason for Concern: For hospital pharmacies using only sterile FDA approved products for compounded sterile products we are ensuring that the product contains the appropriate amount of active ingredient. In addition, we are not successful in finding any laboratories in our area that can assay products to determine the amount (e.g. milligrams) of active ingredient in a compounded sterile product. Many laboratories use liquid chromatography-mass spectrometry (LCMS) that uses mass analysis and physical separation techniques to determine if a substance displays the same LCMS properties as a reference compound. This assay does not determine for instance a milligram amount of a substance in a compounded product so it would not meet the proposed regulation. Solution: Remove “potency” from the “integrity” definition and remove the requirement of the pharmacy determining, maintaining, validating and monitoring potency for compounded products if the source of the CSP’s come from sterile FDA approved products.
1735.8(c)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: Add language between the first and second sentences of 1735.8 (c) to clarify the exact requirements related to the quality assurance plan: “The criteria by which preparations would be tested for potency, quantitative analysis, and labeled strength analysis shall be described in the quality assurance plan. Rationale: This language could be interpreted to require that quantitative and qualitative analysis be performed on all compounded products regardless of cost, availability of the actual assay, or scientific validity. It has been our experience that some Board of Pharmacy inspectors have interpreted this language to require end product potency testing during of all pharmacy-compounded products. KP and many pharmacy professionals disagree with those requirements as they are inconsistent with the intent and provisions of the regulation 1735, et. seq. Pharmacies are compliant with 1735.8(c) if they have a PLAN that includes the elements mentioned above. Quantitative and qualitative laboratory type testing is not required unless specified for each product in our policies and procedures generally or by category - or in the Master Formula for a particular product. Test records of tests only have to be retained if such test was done either as a matter of policy or pursuant to an investigation after the raising of a quality concern for particular compounded preparation or a batch of a compounded preparation.
1735.8(e)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: Delete the words “including for preparations furnished to patient care areas,” or define the term patient care area in Section 1735.1 Rationale: The proposed language “including for preparations furnished to patient care areas” is ambiguous. An outpatient Physician’s office can be considered a patient care area. The current language would require the pharmacy to be responsible for monitoring the storage temperatures after the preparation has been sold/transferred to a Physician’s office.

Code Section	Commenter	Comment
1735.8(e)	California Society of Health-System Pharmacists Dawn Benton	Recommend deleting “including for preparations furnished to patient care areas”. Rationale: Other than for patient care areas in a hospital, the compounding pharmacy is not authorized or responsible for medication storage such as compounded preparations furnished to a prescribers office.
1751	California Pharmacist Association Brian Warren	First, we recommend modification of these proposed regulations to include an exemption of emergency eye-rinsing stations from the prohibition on sinks. Second, because air quality standards for buffer areas and PECs are already present in Section 1735.1, we recommend striking the reference to the ISO classes in this section. Removing these references has no legal impact on this section but makes it easier to comprehend. (3) A sink shall be included in accordance with Section 1250 of Title 24, Part 2, of the California Code of Regulations. Sinks and drains shall not be present in ~~an ISO Class 7 or better~~ a buffer area, nor within three feet of ~~an ISO Class 5~~ a PEC located in a segregated compounding areas, **with the exception of emergency eye-rinsing stations**. A sink may be located in an ante-area.
1751	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	This part of the regulation does not take into consideration that on a Satellite Pharmacy (a non USP 797 cleanroom) the designated compounding and segregated compounding area are the same thing. (See comments in 1735.1q) An ISO Class 5 laminar airflow hood is both of these and needs to be recognized within the regulation. In current clinical practice first doses [sterile to sterile compounding] made in such an environment meet all required sterility issues for patient care. As such the environmental requirements should actually apply only to the compounding area within the laminar airflow hood not the pharmacy satellite environment. As written this would forbid the compounding of any product outside a USP797 compliant compounding area which would basically negate one of the basic tenants of Satellite Pharmacies which is the ability to compound first dose intravenous products in an ISO5 laminar airflow hood. It will return clinical practice to bedside compounding by nurses, a proven risky practice to patients. Again, 1751.1 Recordkeeping Requirements assumes that compounding is done in a USP 797 clean room as these records would not apply to compounding done for immediate first doses in a Satellite Pharmacy.
1751(b)(3)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	It may not be possible to move an existing PEC or sink that is currently within three feet of each other in a pharmacy satellite without major construction that would disrupt patient care. Are there any exceptions to this regulation (e.g., if there is a physical barrier/wall between the PEC and sink)?

Code Section	Commenter	Comment
1751(b)(3)	Community Regional Medical Center Bruce Lepley, Director of Pharmacy	Reason for Concern: Many hospitals have established pharmacy satellites nearby patient care areas to serve our most vulnerable patients (e.g. Intensive Care Units).The central pharmacy is too far from these patient care areas and the pharmacy satellites provide a venue to provide patient care that is closer to the patients. These pharmacy satellites are one room that provides a place for the pharmacy to perform order verification, drug storage, and drug preparation. Many of the pharmacy satellites have very limited room, thus the pharmacy will place compounding aseptic containment isolators (CACIs) which are enclosed to the surrounding environment and should have evidence from the manufacturer that they meet USP chapter 797 and Controlled Environment Testing Association (CETA) requirements. We believe that we can remove the 3 foot no sink/drain requirement when CACI's are used to support pharmacy satellites. The alternative would be to close these pharmacy satellites that do not have the room to abide by the 3 foot no sink/drain rule which is not consistent with a patient centered care model. Solution: Make an exception that if the ISO Class 5 PEC is a CACI, that the three foot sink/drain rule does not apply while maintaining that sinks and drains should not be placed in a buffer area or in ISO class 7 or better.
1751(b)(4)	Douglas Barcon, Pharm.D., Barcon & Associates	Suggest add at end: "Food shall not be stored in refrigerators and/or freezers designated for storage of such materials."
1751.1(a)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: Add language that supports the use of methods other than daily logs, for example, "daily documentation of room, refrigerator, and freezer temperatures, through the use of paper logs or continuous temperature monitoring devices with appropriate alarms/alerts. Rationale: This language, particularly the phrase "daily documentation" could be interpreted to mean that only paper logs would be acceptable. Continuous electronic monitoring technology is at least as good as, if not superior to, manual documentation on paper logs, Recommendation: Add language that supports the use of methods other than daily logs for air velocity, for example, "Daily documentation of air pressure differentials or air velocity between adjoining all ISO rooms or areas and measurement between all ISO rooms or areas, including those associated with compounding aseptic (containment) isolators, through the use of paper logs or continuous monitoring devices with appropriate alarms/alerts." Rationale: This language, particularly the phrase "daily documentation" could be interpreted to mean that only paper logs would be acceptable. Continuous electronic monitoring technology is at least as good as, if not superior to, manual documentation on paper logs or continuous monitoring devices with appropriate alarms/alerts."

Code Section	Commenter	Comment
1751.1(a)(3)	Hartley Medical, William Stuart	a. Comment: I am asking the board to clarify the intention of performing fingertip testing in association with media fill testing. It is our perception that fingertip testing provides useful information, but does not demonstrate a lack of aseptic technique. At my institution we have performed fingertip assessment during media fills, and as of this date have yet to detect a media fill failure in association with detecting colony forming units upon fingertips. b. Recommendation: I recommend removing fingertip assessment after media fill test.
1751.1(a)(5)	California Society of Health-System Pharmacists Dawn Benton	Recommend allowing continuous temperature monitoring. Rationale: Current technology is often used for electronic monitoring and alerting regarding temperature ranges.
1751.1(a)(5)	Douglas Barcon, Pharm.D., Barcon & Associates	Suggest following change: (a)(5) Daily documentation of room HUMIDITY consistent with 1751.4 (j), AND~~,~~ refrigerator~~,~~ and freezer temperatures appropriate for drug preparations consistent with the temperatures listed in section 1735.1 for:
1751.1(a)(5)	Providence Heath & Services Southern California Region	Add to section 1751.1(a)(S): If the compounding facility uses a continuous temperature recording device, compounding personnel shall verify at least once daily that the recording device itself is functioning properly. As noted for 1735.5(c)(10), Providence recommends adding the qualifying language from USP 797 to consistently align with the national standards. Our refrigeration units provide continuous temperature monitoring and alert systems. Daily documentation would not provide an advantage to this 24/7monitoring nor does it increase patient safety beyond the systems already in place.
1751.1(a)(7)	California Society of Health-System Pharmacists Dawn Benton	Recommend allowing continuous airflow monitoring. Rationale: Current technology is often used for electronic monitoring and alerting regarding airflow ranges.
1751.1(a)(7)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	I am not aware of a device that can be placed in an area to determine on a daily basis (or continuously) the air velocity across a line of demarcation. A qualified technician as described in 1751.4 can determine the air velocity across the line of demarcation between an buffer and ante-area using special equipment they possess and are trained to use. Consider deleting the word “Daily” at the front of the sentence, and insert it after the word “differentials”. Consider inserting the words “every 6 months during clean room certification” after the word “velocity” or after the word “isolators” for readability.

Code Section	Commenter	Comment
1751.1(a)(7)	Providence Heath & Services Southern California Region	Daily documentation of air pressure differentials, when applicable, or air velocity between all adjoining ISO rooms or areas and measurement between all ISO rooms or areas, including those associated with compounding aseptic (containment) isolators. Providence recommends including the wording "when applicable." This is because facilities without cleanrooms or buffer areas within anterooms cannot have pressure differentials so a log would not be required.
1751.1(a)(7)	Community Regional Medical Center Bruce Lepley, Director of Pharmacy	**Reason for Concern:** The language is repetitive and unclear ("adjoining all ISO" and "between all ISO"). The inclusion of compounding aseptic (containment) isolators is unclear as to what needs to be documented. **Solution:** Strike repetitive language and delete language on the requirement for CACIs.
1751.2(d)	Harbor Compounding Pharmacy Mai Tran and Sam Kitahara	The proposed language does not specifically define a hazardous drug, and because of the generalization, hazardous drugs can be defined as any hazardous drug defined by the NIOSH List of 2012, which can include antineoplastic, hormones, gonadotropins, oxytocics, antipyschotics, etc. We recommend that the proposed language be more specific by defining hazardous drugs as any drug that is considered an antineoplastic agent in the NIOSH List, or removing the term hazardous drug altogether and replace with antineoplastic drugs. Recommended language: "All antineoplastic agents shall bear a special label which states "chemotherapy - dispose of properly" if applicable." Or All hazardous agents shall bear a special label which states "Hazardous - dispose of properly" or "chemotherapy - dispose of properly" if applicable. A hazardous drug is any antineoplastic agent that is listed on the NIOSH List of Antineoplastic and Other Hazardous Drugs.
1751.3	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	The policy and procedure requirements are in two sections of the regulations each having some of the same requirements and some different. It makes it extremely difficult to understand and comply with all aspects when they are found in different locations in the law
1751.3(a)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Please consider deleting the word "written". This will allow pharmacies to maintain electronic policy and procedures, which are more easily retrievable. There are many facilities that are using systems to electronically store and track policy and procedure archiving, renewals, revisions, and due dates.
1751.3(a)(2)	Cedars-Sinai Katherine Palmer Rita Shane	Recommend exemption for requiring rate on the label for hospital patients since rates change multiple times per day based on the patient's condition (e.g. heparin,dopamine, nitroprusside). The medical record provides the most current order and therefore is the source of truth for the rate of administration.
1751.3(a)(7)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	Again impossible for first dose compounding in Pharmacy Satellites (non USP 797 cleanrooms) see 1735.5c4 comments**.**
1751.3(b)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Please consider deleting the word "in writing". This will allow pharmacies to maintain electronic master formula records, which are more easily retrievable.

Code Section	Commenter	Comment
1751.3(c)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Please consider deleting the word “written”. This will allow pharmacies to maintain electronic policy and procedures, which are more easily retrievable. There are many facilities that are using systems to electronically store and track policy and procedure archiving, renewals, revisions, and due dates.
1751.3(d)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Please consider deleting the word “written”. This will allow pharmacies to maintain electronic policy and procedures, which are more easily retrievable. There are many facilities that are using systems to electronically store and track policy and procedure archiving, renewals, revisions, and due dates.
1751.3(d)(1)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Please consider deleting the word “written”. This will allow pharmacies to maintain electronic policy and procedures, which are more easily retrievable. There are many facilities that are using systems to electronically store and track policy and procedure archiving, renewals, revisions, and due dates.
1751.3(d)(2)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Please consider deleting the word “written”. This will allow pharmacies to maintain electronic policy and procedures, which are more easily retrievable. There are many facilities that are using systems to electronically store and track policy and procedure archiving, renewals, revisions, and due dates.
1751.3(d)(3)(M)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Consider changing the word “prevention” to “preventative”.
1751.3(d)(4)(B)(iii)	Sutter Health Jeannette Hanni	Current: "Appropriate sterility and bacterial endotoxin testing" Issue: No endotoxin testing required for sterile to sterile compounding. Recommend reverse B.iii with C.ii. Low-risk and medium-risk preparations would only require sterility testing if extended procedures beyond-use dating was being used.
1751.3(d)(4)(B)(iii)	California Society of Health-System Pharmacists Dawn Benton	Recommend deleting “and bacterial endotoxin”. Rationale: Endotoxin testing is not an industry standard for sterile to sterile preparations and should be reserved for nonsterile to sterile preparations
1751.3(d)(4)(B)(iii)	Cedars-Sinai Katherine Palmer Rita Shane	Adopt USP 797 which requires bacterial endotoxin (pyrogen) testing for non-sterile to sterile compounding.

Code Section	Commenter	Comment
1751.3(d)(4)(B)(iii)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: “For sterile to sterile batch compounding: appropriate end product examination.” Rationale: According to USP Chapter 797, which is a National Standard, sterility and bacterial endotoxin testing is not routinely required for sterile to sterile batch compounding There are many common scenarios involving sterile to sterile transfers, where this requirement is inappropriate – e.g. compounding injectable antibiotics in hospitals; compounding nine day supplies of total parenteral nutrition solutions and injectable antibiotics for administration to patients at home. These are all low risk and medium risk preparations. The current language would require unnecessary testing and possibly delay therapy to patients. It has been our experience that some Board of Pharmacy inspectors are incorrectly interpreting “end product examination” to mean “end product testing”. We therefore believe it is necessary to define “end product examination” and have included that in the recommendations above to ensure it meets specifications.
1751.3(d)(4)(B)(iii)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	This subdivision requires a written policy and procedure regarding appropriate sterility and bacterial endotoxin testing but does this subdivision require a facility to actually conduct these validations if the facility is not doing “high risk” compounding and is not exceeding USP 797 BUDs? If so, I would like to raise a concern that **sterile “batch” compounding** in accordance with the proposed definition outlined in 1735.1(b) may not warrant tests for sterility or bacterial endotoxins. Please strongly consider revising this language so it is more in line with USP 797. For example, sterility testing is warranted in circumstances that the assigned BUD exceeds the timeframes specified in the proposed sections of 1751.8. Endotoxin testing warranted for “high risk” in the circumstances described in USP 797. If a batch consists of two doses, the testing would not be possible without destroying all of the finished preparation.
1751.3(d)(4)(B)(iii)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	Currently states, “Appropriate sterility and bacterial endotoxin testing”, no endotoxin testing required for sterile to sterile compounding. Recommend reverse B.iii with C.ii. Low risk and medium risk preparation would only require testing if extended beyond use dating was being used.
1751.3(d)(4)(B)(iii)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	For sterile to sterile batch compounding, sterility and bacterial endotoxin testing would not be practical for preparations with a short BUD (e.g. 24 hours). The preparations would be dispensed and administered long before the results of the tests. The compounding pharmacy would ensure sterility of the product through use of aseptic technique, proper hand hygiene/garbing, and compounding within a certified ISO Class 5 PEC. Sterility and bacterial endotoxin testing should only be required for preparations given a BUD longer than recommended by USP 797.

Code Section	Commenter	Comment
1751.3(d)(4)(B)(iii)	Community Regional Medical Center Bruce Lepley, Director of Pharmacy	**Reason for Concern:** This section addresses sterile to sterile batch compounding and bacterial endotoxin testing is only mentioned in the context of non-sterile to sterile compounding in USP <797>. While sterility testing may be performed in the pharmacy, bacterial endotoxin testing will need to be sent to an outside facility. This may pose an access issue due to limited numbers of labs available for this procedure as well as a financial burden. Bacterial endotoxin testing may not provide useful information to the pharmacy due to the delay in test results. Solution: Delete “bacterial endotoxin.”
1751.3(d)(4)(B)(iii)	Providence Heath & Services Southern California Region	Remove sterility and endotoxin testing verbiage from 1751.3(d)(4)(B)(iii) and add itto 1751.3(d)(4)(C) section on non-sterile to sterile compounding: * USP 797 guidelines require sterility and bacterial endotoxin testing only for high-risk level (i.e. non-sterile to sterile) compounding prepared in groups of more than 25 individual single-dose packages. * Low-risk and medium-risk preparations would only require sterility testing if extended beyond- use dating was being used per USP 797.
1751.3(d)(4)(C)(ii)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: Use the term “end-product examination” as defined above and add to this sub-section regarding non-sterile to sterile batch compounding “Passing the sterility test in accordance with methodologies and processes found in Chapter 71 of the United States Pharmacopeia-National Formulary (USP37-NF32) through 2nd Supplement (37th Revision, Effective December 1, 2014), and testing for pyrogens in accordance with the methods of Chapter 85 and 151 of the United States Pharmacopeia – National Formulary (USP37-NF32) through 2nd Supplement (37th Revisions, Effective December 1, 2014), hereby incorporated by reference.” Rationale: According to USP Chapter 797, End Product Sterility and bacterial endotoxin testing is required for non-sterile to sterile batch compounding.
1751.3(d)(4)(L)	Providence Heath & Services Southern California Region	Providence requests definition of acceptable humidity levels for controlled storage areas. Humidity level for the compounding area is defined in Section 1751.4(j) however, humidity level for the controlled storage area is not specified elsewhere.
1751.4(d) and (d)(2)	Douglas Barcon, Pharm.D., Barcon & Associates	Suggest adding “and drug” after word “batch” and before semicolon in (d)(2). Optionally could add “after each change of drug” as individual line and renumber, or not make change and assume compounder would interpret (d)(4) to include a drug change. Rationale: For example a multi-dose piperacillin/tazobactam infusion bag is compounded and then is followed by a potassium phosphate infusion bag. Cleaning would prevent possible penicillin cross contamination.

Code Section	Commenter	Comment
1751.4(d)(2)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend remove subsection (2). Rationale: Inconsistent with industry standards and hospital practice under the proposed definition of a “batch”.
1751.4(d)(2)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Cleaning and disinfecting surfaces of the ISO Class 5 PEC before and each batch may be an unreasonable frequency and would be a significant operational impact considering how SBOP is proposing to define “batch”.
1751.4(d)(2)	California Society of Health-System Pharmacists Dawn Benton	Recommend remove subsection (2). Rationale: Inconsistent with industry standards and hospital practice under the proposed definition of a “batch”.
1751.4(e)	Cedars-Sinai Katherine Palmer Rita Shane	Sterile alcohol is not recommended for cleaning floors by USP 797 due to the potential for flammability and increasing the risk of employee injuries due to falls. Germicidal agents alone are recommended for disinfecting floors,and germicidal agents in combination with sterile isopropyl alcohol are recommended for critical work surfaces (such as the inside of hoods).
1751.4(e)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend replacing with: “Counters, tables, and cleanable work surfaces shall be cleaned with a germicidal detergent and water and disinfected with a suitable agent (e.g., sterile isopropyl alcohol) daily.. Floors shall be cleaned with a germicidal detergent and water daily Walls, ceilings, storage shelving, and stools shall be cleaned with a germicidal detergent and water monthly. Cleaning and disinfecting shall occur after any unanticipated event that could increase the risk of contamination. Rationale Cleaning large surgace areas, such as floors and walls, etc. with Isopropyl alcohol, which is highly flammable, can create a substantial fire hazard which would be especially dangerous in hospitals and patient care areas. Using “sterile isopropyl alcohol” widely is also very costly without justification for certain surfaces. Daily cleaning of floors with a non-flammable agent is reasonable.
1751.4(e)	California Society of Health-System Pharmacists Dawn Benton	Recommend replacing with: Counters, tables, and cleanable work surfaces shall be cleaned with a germicidal detergent and water and disinfected with a suitable agent (e.g., sterile isopropyl alcohol) daily. Floors shall be cleaned with a germicidal detergent and water daily walls, ceilings, storage shelving, and stools shall be cleaned with a germicidal detergent and water monthly. Cleaning and disinfecting shall occur after any unanticipated event that could increase the risk of contamination Rationale: The use of large amounts of isopropyl alcohol is impractical and can become a fire hazard. (See the CDC’s website on disinfecting the healthcare environment. http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf)

Code Section	Commenter	Comment
1751.4(e)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	Such rigorous cleaning should not be required for non-cleanroom areas such as pharmacy satellites. These areas are not controlled environments and do not provide ISO Class 8 air or better. In other words, they are not sterile environments and should not be cleaned as if they are sterile environments. In these areas, compounding is performed only for urgent, first dose preparations. Cleaning/disinfection should be performed within the ISO Class 5 PEC, the only controlled area in a pharmacy satellite. The mentioned cleaning in 1751.4(e) should be enforced in controlled environments only. Separate cleaning procedures for non-ISO classified satellites are needed.
1751.4(e)	Central Admixture Pharmacy Services, Inc William Jones	Change the wording in section (e) to read: Counters, cleanable work surfaces and floors shall be cleaned with a germicidal agent and water and disinfect with a suitable agent. … Many pharmacies may be using a sporicidal agent followed by sterile isopropyl alcohol which may be superior to the method written in the proposal.
1751.4(e)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	Recommend the following language for increased clarification: “Counters, tables, and cleanable work surfaces shall be cleaned with a germicidal detergent and water and disinfected with a suitable agent (e.g., sterile isopropyl alcohol) daily. Floors shall be cleaned with a germicidal detergent and water daily. Walls, ceilings, storage shelving, and stools shall be cleaned with a germicidal detergent and water monthly. Cleaning and disinfecting shall occur after any unanticipated event that could increase the risk of contamination.”
1751.4(e)	Douglas Barcon, Pharm.D., Barcon & Associates	Consider disinfection of floors and walls with disinfection agents other than sterile isopropyl alcohol in the e.g. example to prevent generation of large amounts of alcohol vapor in an enclosed space or keeping alcohol and adding alternative agents. Such alternative agents could include, quaternary ammonium disinfectants and 10% bleach based on surface compatibility.
1751.4(e)	Scripps Health-contact Amy Benner	Recommend change in language to clarify cleaning agents to be used. Isopropyl alcohol should only be used on **work** surfaces (LAFW/BSC/CACI/CAI etc.), carts and counters. Cleaning the entire room with IPA would be a fire hazard. Also include the use of a sporicidal agent at least monthly to clean all areas. Specific language changes recommended as follows: Counters, and cleanable work surfaces (eg. LAFW) ~~and floors~~ shall be cleaned with a germicidal detergent and water and disinfected with a suitable agent (eg. sterile isopropyl alcohol) daily. Floors shall be cleaned with a germicidal detergent daily. Walls, ceilings, storage shelving, tables and stools shall be cleaned with a germicidal detergent and ~~water and disinfected with a suitable agent (eg. Sterile isopropyl alcohol)~~ monthly. A cleaning agent with sporicidal properties shall be used at least once per month in place of the germicidal detergent on all surfaces.

Code Section	Commenter	Comment
1751.4(f)	California Pharmacist Association Brian Warren	(f) Pharmacies **shall compound** ~~preparing~~ sterile ~~compounded~~ preparations ~~require~~ **with** the use of a PEC that provides ISO Class 5 air or better. Certification and testing of primary and secondary engineering controls shall be performed no less than every six months and whenever the device or area designated for compounding is relocated, altered or a service to the facility is performed that would impact the device or area. Certification must be completed by a qualified technician who is familiar with certification methods and procedures in accordance with CETA Certification Guide for Sterile Compounding Facilities (CAG-003-2006-11, Revised January 31, 2012). Certification records must be retained for at least 3 years. Compounding aseptic isolators or compounding aseptic containment isolators may be used outside of an ~~ISO Class 7~~ a buffer area if the isolator meets the following criteria.
1751.4(g)	California Society of Health-System Pharmacists Dawn Benton	Recommend adding the following sentence after "regardless of whether the drug ingredients are considered hazardous.": "Unless the hazardous drug PEC is decontaminated before nonhazardous drugs are compounded in the same PEC. Rationale: In small oncology preparation environments that have only one PEC, it is impractical to decontaminate the PEC between compounding each oncology preparation. However, the environment should be decontaminated before compounding a nonhazardous preparation.
1751.4(g)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: Add an additional sentence to the proposed language: "…must be labeled as hazardous, regardless of whether the drug ingredients are considered hazardous. Unless the hazardous drug PEC is decontaminated before the non-hazardous drugs are compounded." Rationale: In small Oncology Pharmacies serving prescriber offices and clinics, that have only one primary engineering control, e.g. a biological safety cabinet, to compound hazardous and non-hazardous preparations, and if the hood is decontaminated between compounding hazardous and non-hazardous preparations, it would be appropriate to exclude the requirement to label non-hazardous drugs as "hazardous".
1751.4(g)	California Pharmacist Association Brian Warren	During the hazardous drug compounding that is performed in a compounding aseptic containment isolator, full hand hygiene ~~and garbing~~ must occur, complete with ~~hair cover, facemask, beard cover (if applicable), polyprophylen or low shedding gown that closes in the back, shoe covers, and~~ two layers of gloves that have been tested to meet ASTM 6978-05 with the outermost glove that contacts the sterile drug preparation.
1751.4(g)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	The language regarding the gloves is confusing. Is it intended that the outermost glove that contacts the sterile drug preparation must have been tested to meet ASTM 6978-05? If so, it reads that both layers of gloves must have been tested to meet ASTM 6978-05.
1751.4(g)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	Clarification is needed if this is only required for ISO classified rooms. If this is also required for non-ISO classified rooms (e.g. pharmacy satellites), clarification is needed on the proper gowning procedure. The shoe covers are one of the first things donned since it is considered dirty. Hand hygiene would occur far from the segregated compounding area in a non-ISO classified room. If shoe covers are donned first, they would get dirty outside of the segregated compounding area. If shoe covers are donned last immediately outside the segregated compounding area the hands would get dirty again. Separate hand hygiene and garbing procedures for non-ISO classified satellites are needed.

Code Section	Commenter	Comment
1751.4(g)	UCSD Research Pharmacy Leticia Muttera, Pharm. D	? Unless rigorously decontaminated and a certain amount of time has passed between compounding hazardous and non-hazardous preparations. For those of us who do investigational agents and do extremely low volume, we often need to use the same PEC for both hazardous and non-hazardous. Labeling everything as hazardous may cause concern to subjects when their medications are labeled as hazardous when they are not. Often biohazards can be decontaminated using good hood cleaning techniques with acceptable cleansers and chemicals. Air and surface sampling perhaps can also serve as confirmation of decontamination.
1751.4(g)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	This section is confusing because hazardous and non-hazardous compounding are both discussed in the same sections. Please separate out the regulations for hazardous and non-hazardous compounding. Labeling drugs that may have been compounded in a biological safety cabinet that was used to compound a hazardous drug as hazardous would be extremely confusing to the nursing staff that rely on the information on the label for their gowning/disposal procedures. We would have total confusion in the institution as to what products require hazardous precautions and what products do not should this regulation be followed. Instead of changing to labeling of products, the regulations should stress thorough decontamination and cleaning in between hazardous and non-hazardous compounding.
1751.4(g)	Providence Heath & Services Southern California Region	Pharmacies preparing sterile hazardous agents shall do so in accordance with Section ~~505.12.1~~ 505.5.1 of Title 24, Part 4, Chapter 5, of the California Code of Regulations. In 2010, the Building Standards Commission moved the sections applicable to *Pharmacies- Compounding Area of Parenteral Solutions* to Title 24, Part 4, Chapter 5, 505.5. Section 505.5.1addresses the hoods required for cytotoxic agents.
1751.4(g)	Providence Heath & Services Southern California Region	Recommend removing this from 1751.4(g) and adding this to section 1751.2 under Sterile Compounding Labeling Requirements as 1751.2(e). This requirement fits more consistently with the other labeling requirements including the hazardous sterile compounded preparation labeling requirements.
1751.4(g)	Providence Heath & Services Southern California Region	Recommend removing this from 1751.4(g) and adding this to section to 1751.5 Sterile Compounding Attire. This requirement builds upon the hazardous drug compounding attire requirements already listed in 1751.5(b) by including more details about which personal protective equipment must be used for all hazardous drug preparations in addition to a compounding aseptic containment isolator

Code Section	Commenter	Comment
1751.4(i)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: Include the USP Chapter 797 definitions for medium risk-level and high risk-level compounding in the definitions section (1735.1). Adopt the language in USP Chapter 797 for the frequency of the sampling plan, e.g. “Environmental sampling shall occur as part a comprehensive quality management program and shall occur minimally under any of the following conditions: 1. As part of the commissioning and certification of new facilities and equipment 2. Following any servicing of facilities and equipment 3. As part of the re-certification of facilities and equipment, at least every 6 months 4. In response to identified problems with compounded preparation or staff technique 5. In response to issues with CSPs, observed compounding personnel work practices, or patient-related infections (where the CSP is being considered as a potential source of the infection).” Rationale: The definitions for medium risk level and high risk level compounding are not included in the definitions. The frequency of sampling is over burdensome and without merit scientifically.
1751.4(i)	California Pharmacist Association Brian Warren	Viable surface sampling shall be done at least **quarterly** ~~monthly~~ for low and medium risk- level compounding and **monthly** ~~weekly~~ for high-risk compounding. Volumetric air sampling by impaction shall be done at least once every six months ~~for low and medium risk-level compounding and weekly for high-risk compounding~~. Viable surface and volumetric air sampling shall be performed by a qualified individual who is familiar with the methods and procedures for surface testing and air sampling. Viable air sampling is to be performed under dynamic conditions that simulate actual production. Surface sampling is to be performed under dynamic conditions of actual compounding. When the environmental monitoring action levels are exceeded, **as defined by [***]**, the pharmacy shall identify the CFUs at least to the genus level in addition to conducting an investigation. Remediation shall include an immediate investigation of cleaning and compounding operations and facility management. **As used in this subdivision, “low risk compounding,” “medium risk compounding,” and “high risk compounding ” have the meanings defined in Chapter 797 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference.**
1751.4(i)	California Society of Health-System Pharmacists Dawn Benton	Recommend including USP 797 definitions for medium and high risk compounding. Adopt the USP 797 standard for frequency of sampling environmental surfaces. Rationale: The proposed regulation provision is inconsistent with industry standard and hospital practice and is impractical and costly to implement.
1751.4(i)	GrayMatter Pharmacy Services, Inc Michael Moore, R.Ph.	You must define action levels. Is it 3 CFU’s? 30? The state board has taken upon itself to micro-manage pharmacy compounding practices, so I do not understand why they are not specifying this number/level within the regulatory language.

Code Section	Commenter	Comment
1751.4(i)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	Monthly and weekly testing is not required by USP 797, the professional standard for compounding sterile preparations. According to USP 797, air sampling is only required at least *semiannually* . For surface sampling USP 797 states that the sampling shall be performed on a *periodic basis* . Monthly and weekly testing would be in excess of what is needed (as compared to USP 797), and would come at a very high cost to the institution.
1751.4(i)	Hartley Medical, William Stuart	a. Comment (1): Surface and Volumetric air sampling on a weekly basis will impose a costly burden to compounding pharmacies involved with high risk compounding. The cost of air sampling devices range from $2000-$10,000 if an individual was to perform this themselves. The cost for an outside vendor to perform this test will range from $200-$500 per test and an additional cost for microbial identification. I strongly believe that environment monitoring is important to ensure a safe compounding environment. b. Comment (2): This regulations states that identification of the CFU, will occur upon test results exceeding action levels. There are two issues here. First is identification only occurs after an excursion beyond action levels. In a particular scenario, the test results may be below an action limit, however the organism may be objectionable such as Escherichia coli. Secondly, many organisms under certain genera are not pathogenic. For example, the genus of Staphylococcus contains many different species found normally on human skin(such as hominis, simulans, and capitis) pose no danger. The main species of clinical significance is Staphyloccocus aureus. Therefore identification of species is imperative. c. Recommendation (1): I am recommending for the committee to consider quarterly or monthly testing. d. Recommendation (2): Microbial identification to genus and species.
1751.4(i)	Douglas Barcon, Pharm.D., Barcon & Associates	Viable surface sampling post disinfection would be a process to validate the effectiveness of the disinfection process. Consider adding surface sampling post disinfection to the current surface sampling performed under dynamic compounding.
1751.4(i)	Providence Heath & Services Southern California Region 20555 Earl Street Torrance, CA 90509	Recommend removing 1751.4(i) and adding this verbiage to 1751.7 Sterile Compounding Quality Assurance and Process Validation. This requirement is part of quality assurance and process validation for the compounding environment.
1751.4(i)	Providence Heath & Services Southern California Region 20555 Earl Street Torrance, CA 90510	Viable surface sampling shall be done at least monthly for ~~low and medium risk level~~ sterile-to-sterile compounding and weekly for ~~high risk~~ non-sterile to sterile compounding. Low, medium, and high-risk levels are not defined in the regulations. These terms must be defined to match the USP 797 criteria for each risk level. The criteria are included in 1751.8(a) through (c) but the terms "low and medium risk-level" and "high-risk" are not used.

Code Section	Commenter	Comment
1751.4(i)	Harbor Compounding Pharmacy Mai Tran and Sam Kitahara	We believe that weekly air sampling testing for high risk compounding would be overly cautious and extremely cost prohibitive for independent sterile compounding pharmacies. Current USP 797 guidelines only require volumetric air sampling for high risk compounding every 6 months. **Air Sampling Frequency and Process—**Air sampling shall be performed at least semiannually (i.e., every 6 months) as part of the re-certification of facilities and equipment. We recommend changing proposed language to: Volumetric air sampling by impaction shall be done at least once every 6 months for low, medium, and HIGH risk level compounding.
1751.4(i)	Community Regional Medical Center Bruce Lepley, Director of Pharmacy	**Reason for Concern:** The most recent USP 797 regulations state that viable surface sampling be done periodically. Many hospitals conduct surface sampling every six months to coincide with the requirements for PEC and cleanroom certification. Pharmacies may also not have access to qualified individuals every month for surface sampling, but would have access to these qualified individuals every six months for the PEC and cleanroom certifications. **Solution:** Reduce the viable surface sampling requirement to every six months.
1751.4(j)	California Pharmacist Association Brian Warren	The proposed regulations establish requirements for a "comfortable, well-lighted working environment," with specific standards for temperature and humidity. While maintaining a comfortable work environment for compounding personnel is advisable, it is unclear that such a requirement belongs in regulations. We recommend that the Board remove the requirements in subdivision (j) or rewrite them to be less specific, such as maintaining a comfortable work environment that is conducive to sterile compounding.
1751.4(j)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	Recommend deleting "which includes a room temperature of" since this applies to personal comfort and not directly to medication or consumer safety
1751.4(j)	UCSD Research Pharmacy Leticia Muttera, Pharm. D	Is temp ≤ 20 degrees C for pharmacies with isolators as well? This temp goes below USP definition of controlled room temp. We typically keep the pharmacy at 20-25 degrees C. Similarly with isolators, does humidity need to be measured? Typically most pharmacies do not measure humidity.

Code Section	Commenter	Comment
1751.4(j)	Sutter Health Jeannette Hanni	Current: "The pharmacy shall have a comfortable and well-lighted working environment, which includes a room temperature of 20 degrees Celsius (68 degrees Fahrenheit) or cooler to maintain comfortable conditions for ompounding personnel when attired in the required....." Recommend deleting this statement "which includes a room temperature of..... since it applies to personal comfort and not to medication or consumer safety. Current: "Humidity levels should be consistent with ASHRAE Standard 55 (30-65% RH). Recommend adding the definition of humidity to the definitions page.
1751.4(j)	GrayMatter Pharmacy Services, Inc Michael Moore, R.Ph.	Are you kidding me? What if I have poor circulation and I need a temperature of 72 or greater or I begin to shiver? Why would the board get into the business of determining what is right for everyone? What about sound levels? What about candle-lumen measurements for light? What about the angle staff might be required to bend over during the compounding process? My recommendation is that this language be stricken or use some useless language such as “every effort will be made to ensure that the work environment will be comfortable.”
1751.4 (j)	Community Regional Medical Center Bruce Lepley, Director of Pharmacy	**Reason for Concern:** In the definitions section you describe a controlled room temperature (page 3) to be between 68 F to 77F and we agree that this is an appropriate range. We believe that maintaining a room temperature range of 68F to 77F in the areas where pharmacy personnel who are compounding in addition to the Room Humidity requirements stipulated in the proposed regulation is sufficient to mitigate risk of particle control in the compounding process. **Solution:** Include that a temperature range of 68F to 77F is appropriate for room temperature to maintain comfortable conditions for compounding personnel.
1751.5(a)(6)	Sutter Health Jeannette Hanni	Recommend adding "severe" before rashes and deleting "sunburn". If a sunburn blisters and runs, it would be included in the category of "open sores".
1751.5(a)(6)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend changing wording to: “Individuals with “exposed” rashes, sunburn…” Rationale: If the conditions are not exposed, a contamination problem is not realistic.
1751.5(a)(6)	California Society of Health-System Pharmacists Dawn Benton	Recommend changing wording to: “Individuals with “exposed” rashes, sunburn…” Rationale: If the conditions are not exposed, a contamination problem is not realistic.

Code Section	Commenter	Comment
1751.5(a)(6)	Providence Heath & Services Southern California Region 20555 Earl Street Torrance, CA 90511	*Individuals experiencing rashes, sunburn, weeping sores, conjunctivitis, active respiratory infections, or those wearing cosmetics shall be excluded from the ISO Class 5 and ISO Class 7 compounding areas until their conditions are remedied.* *Providence recommends adding the specific ISO Classes of the restricted compounding areas to align with the USP 797 guidelines.*
1751.5(a)(6)	GrayMatter Pharmacy Services, Inc Michael Moore, R.Ph.	I believe this was brought up at the public comment last meeting, but if someone has a rash on an unexposed area are they still restricted? Is that considered a remedy?
1751.5(a)(6)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	Recommend in (a). (6) adding “Severe” to rashes and omitting “sunburn”.
1751.5(2)(3)(5)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	Similar to 1751.4(g) clarification is needed on the gowning procedure in a non-ISO classified segregated compounding area such as a satellite. After donning shoe covers, head cover, and face mask, compounding personnel would need to walk away from the segregated compounding area to perform hand hygiene. However, the proposed language states that the personal protective equipment is donned immediately outside of the segregated compounding area. In a non-ISO classified area, it is not possible to gown in this manner. This procedure only makes sense in an ISO classified cleanroom environment where personal protective equipment is donned in the anteroom (ante-area). Separate hand hygiene and garbing procedures are needed for non-ISO classified rooms. Gloves to be disinfected by sterile isopropyl alcohol does not make sense in a non USP 797 cleanroom environment.
1751.6(e)(1)(E)	McGuff Compounding Pharmacy Services, Inc William J. Blair, Pharm.D., MBA Vice President and Director of Pharmacy Services	Comment: Change to “the same amount or greater” to allow some flexibility
1751.6(i)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	This regulation mixes sterile to sterile compounding training with non-sterile to sterile compounding training. These need to be separated as not all staff will be performing both, and the requirement should fit the actual practice.

Code Section	Commenter	Comment
1751.7(a)	San Mateo Medical Center Gary L. Horne, Director of Pharmacy	In addition to the comments above, it should be noted that the language that reads "...end product shall be examined on a periodic sampling basis as determined by the pharmacist-in- charge to assure that it meets required specifications." does not state that laboratory qualitative and quantitative analysis be performed. Current guidelines such as the 2014 ASHP Guidelines on Compounding Sterile Preparations and USP Chapter <797> both state that end product sterility testing is not required for preparation of low and medium risk CSP, provided those CSP are assigned an appropriate BUD and stored accordingly. It is important that pharmacies understand that laboratory testing for sterility should not be required for sterile preparations compounded on a one-time basis for administration within seventy two {72} hours to an inpatient in a health care facility licensed under section 1250 of the Health and Safety Code and stored in accordance with standards for "Redispensed CSPs" found in Chapter 797 of the United States Pharmacopeia- National Formulary {USP37-NF32) Through 2nd Supplement {37th Revision, Effective December 1, 2014}, hereby Incorporated by reference." If the CSP is compounded by the health care facility.
1751.7(a)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Please consider deleting the word “written”. This will allow pharmacies to maintain electronic policy and procedures, which are more easily retrievable. There are many facilities that are using systems to electronically store and track policy and procedure archiving, renewals, revisions, and due dates.
1751.7(b)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	1. The volume transferred during the compounding process may vary in amount depending upon the final amount of sterile drug preparation produced. If the SBOP of pharmacy desires to mimic every variation in volume possible during the compounding process the number of media fill tests required would be infinite and not practical. Recommend revise the sentence as follows: The media fill testing process shall be as complicated as the most complex manipulations performed by staff~~. and contain the same amount of volume transferred during the compounding process~~.(i.e. insert a period after the word staff and delete the remainder of the sentence.
1751.7(b)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	2. With respect to the “personnel competency” that begins with the 6th sentence agree and support the requirement of media fill testing at least every 12 months for sterile to sterile compounding and at least every six months for individuals compounding sterile products from non-sterile ingredients. However; concerned that the language pertaining to unacceptable quality assurance program results, compounding process or equipment changes/replacements, and facility modifications is too broad and may not be warranted keeping in mind the Media Fill Test (MFT) is a method to determine the skill of personnel to aseptically prepare compounded sterile preparations. For example, when an individual staff member is observed to be using improper aseptic techniques, re-validation of the individuals’ MFT competency after being re-instructed to ensure correction of all aseptic work practice deficiencies is warranted but re-validation of the MFT competency of all personnel is not. Compounding Quality Assurance programs typically include many process or performance indicators; which may or may not be impacted by aseptic work practices, for example, process indicators related to medication storage temperature monitoring. If there were an unacceptable result with this process indicator that is included in the Quality Assurance Program, the language in this section would indicate process re-validation with a MFT would be required. Re-validation should be appropriate to the circumstance(s) and should be specific to the personnel found to be deficient.

Code Section	Commenter	Comment
1751.7(b)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Recommend the following changes: Personnel competency must be revalidated at least every twelve months for sterile to sterile compounding and at least every six months for individuals compounding sterile products from non-sterile ingredients. Aseptic work practice assessments via media fill tests must be revalidated, as appropriate to the circumstance and or personnel found to be deficient, whenever the quality assurance program yields an unacceptable result, when the compounding process changes, equipment used in the compounding of sterile drug preparations are repaired or replaced, the facility is modified in a manner that affects airflow or traffic patterns or whenever improper aseptic techniques are observed.
1751.7(b)	Central Admixture Pharmacy Services, Inc William Jones	Recommend removing the requirement to revalidate personnel when equipment used in the compounding process of sterile drug preparations are repaired or replaced. When compounding equipment such as an automated compounding device is repaired or a new component from the manufacturer has been sent as a replacement this does not change the process and should not require a new validation. It may be more appropriate to require a qualification of the equipment to make certain it is operating properly.
1751.7(b)	McGuff Compounding Pharmacy Services, Inc William J. Blair, Pharm.D., MBA Vice President and Director of Pharmacy Services	Comment: Change to “the same amount or greater” to allow some flexibility
1751.7(c)	California Pharmacist Association Brian Warren	(c) All **sterile** compounding personnel must successfully complete an initial competency evaluation. In addition, immediately following the initial hand hygiene and garbing procedure, all compounding personnel must successfully complete a gloved fingertip sampling procedure (zero colony forming units for both hands) at least three times before initially being allowed to compound sterile drug preparations
1751.7(c)	Hartley Medical, William Stuart	a. Comment: I fail to see the significance and benefit of testing fingertips three times during the gowning and gloving process. This requirement represents that individuals compounding sterile preparations can aseptically don gloves prior to compounding sterile preparations. This requirement does not represent fingertip conditions while compounding sterile preparations under dynamic conditions. b. Recommendation: I recommend removing the requirement of testing fingertips three times during the gowning process, and consider fingertip assessment under dynamic conditions.
1751.7(c)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	Gloved fingertip sampling should only be required for personnel working in ISO-classified areas while wearing sterile gloves. Gloved fingertip sampling in non-ISO classified areas should not apply since there is exposure to non-ISO classified air.
1751.7(e)	Marie Cottman: Hearing Testimony	Direct conflict with USP 797 guidelines for testing products. Batch definition USP 71 does not require pyrogen testing on non-injectable products, ie eye drops. Add faster forms of testing (RDI testing)

Code Section	Commenter	Comment
1751.7(e)	Cedars-Sinai Katherine Palmer Rita Shane	Sterility and pyrogen testing will enable identification of potential patient risks.
1751.7(e)	California Pharmacist Association Brian Warren	First, with respect to the non-sterile ingredients being compounded, only active ingredients should apply for testing. Second, while the standards proposed here closely mirror those in USP 37 <797>, one important exemption in the USP standards was excluded from the proposed regulations. USP 37 <797> establishes end-product testing requirements for high risk compounding. The USP requirements specifically state that "sterility tests for autoclaved CSPs are not required unless they are prepared in batches of more than 25 units." We believe that this standard should carry over into California regulations. The Board states that the intent of the changes to Section 1751.7 is to "[address] the problem of ensuring that board regulations are aligned with compounding standards in USP 37 <797> and reducing such discrepancy for the compounding profession who are compounding drug products in California and shipping into California so as to ensure the safety of all consumers receiving compounded drugs in California." In order to maintain alignment with USP 37 <797>, the sterility testing exception for batches of 25 of fewer should apply to California regulations as well.
1751.7(e)	California Pharmacist Association Brian Warren	Third, we recommend deleting the proposed sentence "This requirement of end product testing confirming sterility and acceptable levels of pyrogens prior to dispensing shall apply regardless of any sterility or pyrogen testing that may have been conducted on any ingredient or combination of ingredients that were previously non-sterile." Per USP 37 <797>, in the absence of sterility and pyrogen testing, the Beyond Use Date assignment is restricted, depending upon the risk level of the sterile compounding (low, medium or high). For example, consider the compounding of alprostadil. A pharmacist will reconstitute the full 500mcg and use that as stock to compound the finished preparation. The pharmacist then performs end product testing of that stock for sterility and pyrogens. Under the above-mentioned requirement, even if the pharmacist compounds a medium risk product (sterile WFI and sterile alprostadil) and dilutes this to a 30mcg/ml, it would be mandated to perform additional end product testing. In our example, per USP 37 <797> sterility and pyrogen testing would only be required at the end-product stage for the pharmacist to assign a BUD of 90 days frozen (in the absence of such testing, the pharmacist would be limited to assigning a BUD of 45 days frozen). Deleting this section is consistent with USP 37 <797> because these proposed regulations adopt USP's beyond use dating requirements in Section 1751.8. Fourth, subdivision (e) provides specific instances and conditions for when a batch-produced sterile drug preparation may be dispensed prior to receipt of test results. The only conditions that such a drug may be dispensed are "where failure to dispense could result in loss of life, or intense suffering." There are other clinically justifiable reasons for releasing the drug quarantine, short of death or intense suffering. We recommend adding "clinically adverse outcome" to the instances in which a drug may be dispensed.

Code Section	Commenter	Comment
1751.7(e)(1)(C)	California Pharmacist Association Brian Warren	subdivision (e)(1)(C) requires written consent by the prescriber when a batch-produced sterile drug preparation is released from quarantine. Prescribers should be able to provide their consent to dispense over the phone, especially given that this only occurs during an emergency. We recommend striking the word “written.”
1751.7(e)(2)(A)	California Pharmacist Association Brian Warren	Delete “Daily observation of the incubating test specimens.”
1751.7(e)(2)(B)	California Pharmacist Association Brian Warren	Limits dispensing of batch-produced sterile drug preparations prior to receiving test results only in such quantity necessary to meet the immediate need. We recommend modifying this to the amount that is “reasonably necessary,” given that the exact amount may not be known at the time of the emergency. A pharmacist should not be penalized if a small number of doses are dispensed but they are not all used.
1751.7(e)(2)(B)	Unknown Speaker at Hearing	Change the wording to pyrogen USP chapter 85 limits as the end point for toxins
1751.7(e)(2)(B)	Hartley Medical, William Stuart	a. Comment: A pyrogen is a lipopolysaccharide section of a bacterial cell wall. A pyrogen cannot biologically grow. I recommend changing the wording to state pyrogen concentration that exceeds USP monograph or USP Chapter <85> endotoxin limits.
1751.7(f)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	Again the wrong definition of ‘batching’ in 1735.1b (see previous) applies here. Incorrect application of the term will lead to interpretation problems. Needs to be clarified.
1751.8	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: Change language to support longer beyond use dating with the use of barrier isolators, provided that these primary engineering controls maintain ISO Class 5 air quality, and meet the requirements delineated in 1751.4(f). Rationale: The current regulatory language does not state that preparations compounded in barrier isolators that meet the requirements delineated in 1751.4(f) may be assigned the Beyond Use Dates as outlined in sections 1751.8 (a)(b)(c). The proposed language does not acknowledge that barrier isolators can provide ISO Class 5 air quality, even when located in a room that does not meet ISO Class 7 conditions. This could be an important strategy for preparing CSPs with beyond use dates exceeding 12 hours in medication satellites or in inpatient pharmacies that do not have a dedicated clean room.

Code Section	Commenter	Comment
1751.8	California Pharmacist Association Brian Warren	In addition to the requirements and limitations of section 1735.2, subdivision (h), **and in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference, that would justify a more extended beyond use date**, every sterile compounded drug preparation shall be given and labeled with a beyond use date that conforms to the following limitations, except that the beyond use date shall not exceed any expiration date or beyond use date provided by the manufacturer for any component in the preparation
1751.8	Hartley Medical, William Stuart	a. Comment: The proposed regulations are based primarily on USP chapter 797. It is my understanding that the USP Sterile Compounding Committee developed the beyond use guidelines based upon consensus and not derived from scientific studies or publications. One of the primary principles of the USP chapter 797 is: "They provide a foundation for the development and implementation of essential procedures for the safe preparation of low-risk, medium-risk, and high-risk level CSPs and immediate-use CSPs, which are classified according to the potential for microbial, chemical, and physical contamination." I have discussed this matter with many clinicians and USP Sterile Compounding Committee Members and their focus has always been on the probability of contamination. Probability does not equal certainty. Also stated in this chapter; "The use of technologies, techniques, materials and procedures other than those described in this chapter is not prohibited so long as they have been proven to be equivalent or superior with statistical significance to those described herein". Our interpretation of this guideline supports alternative methods to produce sterile compounded preparations. In many sections of USP 797 references to USP 795 are noted as it relates to beyond use dating. Within chapter 795 it is stated, "In assigning a beyond use date for a compounded drug preparation, in addition to using all available stability information compounder is also to use his or her pharmaceutical education and experience." Additionally, within USP chapter 797 the section Responsibility of Compounding Personnel: item #10, BUD's are assigned on the basis of direct testing or extrapolation from reliable literature sources and other documentation. There are many concerns with the beyond use date guidelines as it relates to storage and temperature considerations. There are a certain number of compounded preparations that cannot be stored at temperatures below room temperature. More specifically, high concentration intraspinal solutions will precipitate at temperatures less than 21 Celsius (room temperature) and render these preparations unsuitable for administration.
1751.8	GrayMatter Pharmacy Services, Inc Michael Moore, R.Ph.	When I have discussed the difficulties associated with complying with the language in this section as it relates to a small hospital pharmacy with limited space we were told that if we purchased a CAI we would be able to get BUD greater than 12 hours currently afforded to us by the proposed regulation. However, when I read the various "options" for compounding areas it does not appear that we would get BUD greater than 12 hours even if we begin utilizing a CAI. 1751.8(a) describes a PEC in an ISO 7 buffer area, (b) describes the same environment, (c) describes non-sterile to sterile, and (d) describes our current situation. If the language were changed to say "ISO class 5 PEC WITH an ISA 7 buffer area" then I think we would be in compliance. In most CAIs the buffer area is adjacent to the class 5 area of the hood. The class 5 area is not wholly contained in a class 7 area.

Code Section	Commenter	Comment
1751.8	Hartley Medical, William Stuart	Continuation: b. Past Studies on Contamination: There have been many studies addressing the contamination rate of compounded sterile preparations over the past four decades. Many the studies are focused on hospital-based pharmacy settings versus non-hospital based compounding pharmacies. In my review of the studies I found that critical information was omitted. This includes sterile compounding environment, staff gowning, environmental conditions, hand washing and gloving , and sterile gloves versus non-sterile gloves to name a few. I present the following publication; AJHP Vol 62, November 15th, 2005; I.V. Admixture Contamination Rates: Traditional Practice Site Versus a Class 1000 Clean Room. The purpose of this study was to show the contamination rates associated with medium risk CSP's in a traditional practice versus those in a class 1000 clean room. I wish to highlight two important issues. First, this publication stated that the class 1000 clean room received HEPA filtered air and the room air changes per hour (ACPH) were 39.6. This is just over the USP 797 standard. Second, they performed a viable (bacteria) air sampling. Their average number of CFU's per cubic meter was 13. This number of CFU's exceeds USP 797 guidelines. This room was poorly designed in the air changes per hour which were inadequate to properly remove viable and nonviable particulates. I have yet to find a study evaluating the contamination rates of CSP's within an ISO 4 PEC device in an ISO 6 clean room with active viable and non-viable environmental monitoring. c. Recommendation: Consider adding text such as; " For sterile compounded preparations, in the absence of direct sterility testing results or appropriate information sources that justify different limits…". One could also consider incorporating language for process validation to extend beyond use dates.
1751.8(a)	California Pharmacist Association Brian Warren	***A beyond use date of no more than 48 hours at controlled room temperature; 14 days at controlled cold temperature; and 45 days at controlled freezer temperature shall be given to a*** ~~**Where the**~~ sterile compounded drug preparation that was compounded solely with aseptic manipulations **when all of the following apply**:
1751.8(a)(1)	California Pharmacist Association Brian Warren	**The preparation was compounded** entirely within an ISO Class 5 PEC located in an ISO Class 7 buffer area with an ante-area, using only sterile ingredients, products, components, and devices.; ~~**and**~~
1751.8(a)(2)	California Pharmacist Association Brian Warren	The compounding process involves transferring, measuring, and mixing manipulations using not more than three commercially manufactured packages of sterile preparations and not more than two entires into any one sterile container or package of sterile preparations or administration containers/devices to prepare the drug preparation.~~**; and**~~

Code Section	Commenter	Comment
1751.8(a)(3)	California Pharmacist Association Brian Warren	Compounding manipulations are limited to aseptically opening ampules, penetrating disinfected stoppers on vials with sterile needles and syringes, and transferring sterile liquids in sterile syringes to sterile administration devices, package containers of other sterile preparations, and containers for storage dispensing ~~**in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference, that would justify a more extended beyond use date, the beyond use date shall specify that storage and exposure periods cannot exceed the following: 48 hours at controlled room temperature; 14 days at controlled cold temperature; and 45 days at controlled freezer temperature**~~.
1751.8 (a)-(e)	UCSD Research Pharmacy Leticia Muttera, Pharm. D	Or compounding aseptic containment isolator?
1751.8(a)(2)	GrayMatter Pharmacy Services, Inc Michael Moore, R.Ph.	Need to define “mixing manipulations”
1751.8 (a) and (b) and (c)	Community Regional Medical Center Bruce Lepley, Director of Pharmacy	**Reason for Concern:** Compounding aseptic (containment) isolators (CACIs) are discussed in section 1751.4 (f) (1-3) in terms of use outside of an ISO Class 7 buffer area and this beyond use dating section is unclear about the CACIs BUD. The intention of both sections appears that CACIs meeting the criteria in 1751.4 (f) (1-3) may utilize the BUD for compounding in 1751.8 (a-c) and if the CACI does not meet the criteria, the preparations are limited to 12 hour BUD or less. **Solution:** Add language to 1751.8 (a) (1), (b) (1) and (c) “…with an ante-area or within a compounding aseptic (containment) isolator meeting the criteria of section 1751.4 (f) (1-3).”
1751.8(a),(b),and (c)	Providence Heath & Services Southern California Region	Where the sterile compounded drug preparation was compounded solely with aseptic manipulations (1) entirely within an ISO Class 5 PEC ~~located in an ISO Class 7 buffer area with an ante-area,~~ or better air quality. Proposed language restricts sterile compounding with USP 797 defined beyond use dating to only within an ISO 7 cleanroom with an ante-area. USP 797 guidelines allow for sterile compounding within a CAI or CACI that meets all of the operational criteria as defined in Section 1751.4(f) and use of beyond use dating specified. USP 797 high-risk level sterile compounding that aligns with proposed Section 1751.8(c) does not require use of an ISO Class 5 PEC, ISO Class 7 buffer area or ante-area. The language contradicts the last paragraph of the same section 1751.8(c) *For the purposes of this paragraph, "non-sterile" includes sterile contents of commercially manufactured preparations, sterile surfaces of devices, and containers for the preparation, transfer, sterilization, and packaging of compounded sterile preparations, that are exposed to worse than ISO Class 5 air quality for more than one hour.*

Code Section	Commenter	Comment
1751.8(a)(3)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Insert the words “before administration is initiated” after the word “following” to ensure that board regulations are more closely aligned with compounding standards in USP 37 <797> and the beyond use date definition being proposed in CCR 1735.1 (c).
1751.8(a)(3), (b)(3),and(c)	Providence Heath & Services Southern California Region	...in accordance with standards for sterility testing found in Chapter ~~797~~ 71of the United States Pharmacopeia - National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014. USP 797 references USP 71 *Sterility Tests.* Providence recommends referencing USP Chapter 71 directly.
1751.8(b)	Providence Heath & Services Southern California Region	(1) entirely within an ISO Class 5 PEC located in an ISO Class 7 buffer area with an ante area, using multiple individual or small doses of sterile preparations combined or pooled to prepare a compounded sterile preparation that will be administered either to multiple patients or to one patient on multiple occasions; and/or (2) the compounding process involves complex aseptic manipulations other than the single-volume transfer; and/or (3) the compounding process requires unusually long duration such as that required to complete dissolution or homogenous mixing. Providence recommends aligning with *Medium - Risk Level CSPs* conditions which include "one or more" of the listed criteria.
1751.8(b)	California Pharmacist Association Brian Warren	**A beyond use date of no more than 30 hours at controlled room temperature; 9 days at controlled cold temperature; and 45 days at controlled freezer temperature shall be given to a ~~Where the~~** sterile compounded drug preparation **that** was compounded solely with aseptic manipulations **when all of the following apply**:
1751.8(b)(1)	California Pharmacist Association Brian Warren	**The preparation was compounded** entirely within an ISO Class 5 PEC located in an ISO Class 7 buffer area with an ante-area, using multiple individual or small doses of sterile preparations combined or pooled to prepare a compounded sterile preparation that will be administered either to multiple patients or to one patient on multiple occasions.; **~~and~~**
1751.8(b)(2)	California Pharmacist Association Brian Warren	the compounding process involves complex aseptic manipulations other than the single- volume transfer.; **~~and~~**

Code Section	Commenter	Comment
1751.8(b)(3)	California Pharmacist Association Brian Warren	the compounding process requires unusually long duration such as that required to complete dissolution or homogenous mixing ~~**in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference, that would justify a more extended beyond use date, the beyond use date shall specify that storage and exposure periods cannot exceed the following: 30 hours at controlled room temperature; 9 days at controlled cold temperature; and 45 days at controlled freezer temperature**~~.
1751.8(b)(3)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Insert the words “before administration is initiated” after the word “following” to ensure that board regulations are more closely aligned with compounding standards in USP 37 <797> and the beyond use date definition being proposed in CCR 1735.1 (c).
1751.8(b)(3)	GrayMatter Pharmacy Services, Inc Michael Moore, R.Ph.	Like what? I’m going to need examples. Or the state is going to have to come up with a defined time: ex. “if it takes more than 30 seconds to dissolve the powder”
1751.8(c)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	1. Insert the words “before administration is initiated” after the word “following” to ensure that board regulations are more closely aligned with compounding standards in USP 37 <797> and the beyond use date definition being proposed in CCR 1735.1 (c). 2. The text “or where the sterile compounded drug preparation lacks effective antimicrobial preservatives” is taken out of context relative to USP 797 applicability when compounding sterile products outside of an ISO Class 5 environment. If adopted as proposed, the beyond use dating requirements described in this regulation would be applied when a sterile preparation that contains a non-preserved ingredient is compounded within an ISO class 5 PEC located in an ISO Class 7 buffer area with an ante-area. This would unnecessarily impose the more conservative beyond use date requirements normally assigned to “high risk” compounding resulting in increase expense and waste of drug resources as a result of the shorted “shelf life”.

Code Section	Commenter	Comment
1751.8(c)(1)	California Pharmacist Association Brian Warren	**A beyond use date of no more than 24 hours at controlled room temperature; 3 days at controlled cold temperature; and 45 days at controlled freezer temperature shall be given to a ~~Where the~~** sterile compounded drug preparation **that** was compounded solely with aseptic manipulations entirely within an ISO Class 5 PEC located in an ISO Class 7 buffer area with an ante-area, using non-sterile ingredients, including manufactured preparations not intended for sterile routes of administration, or non-sterile devices, before terminal sterilization, or where the sterile compounded drug preparation lacks effective antimicrobial preservatives, **~~in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference, that would justify a more extended beyond use date, the beyond use date shall specify that storage and exposure periods cannot exceed the following: 24 hours at controlled room temperature; 3 days at controlled cold temperature; and 45 days at controlled freezer temperature~~**.
1751.8(c)(2)	California Pharmacist Association Brian Warren	For the purposes of this **subdivision ~~paragraph~~**, "non-sterile" includes sterile contents of commercially manufactured preparations, sterile surfaces of devices, and containers for the preparation, transfer, sterilization, and packaging of compounded sterile preparations, that are exposed to worse than ISO Class 5 air quality for more than one hour.
1751.8(d)	California Pharmacist Association Brian Warren	**A beyond use date shall specify that storage and exposure periods cannot exceed 12 hours in a laminar air flow workbench or biological safety cabinet when ~~Where~~** the sterile compounded drug preparation was compounded solely with aseptic manipulations **and all of the following apply:**
1751.8(d)(1)	California Pharmacist Association Brian Warren	**The preparation was compounded** entirely within an ISO Class 5 PEC that is located in a segregated compounding area and restricted to sterile compounding activities, using only sterile ingredients, components, and devices, by personnel properly cleansed and garbed**~~.; and~~**
1751.8(d)(1)	Providence Heath & Services Southern California Region	*(1) entirely within an ISO Class 5 PEC that is a compounding aseptic isolator (CAI} or a compounding aseptic containment isolator (CACI) that does not meet the requirements described in Section 1751.4(/) or is a laminar airflow workbench (LAFW) or a biological safety cabinet (BSC) that is located in a segregated compounding area and restricted to sterile compounding activities,...* *Proposed language in this section does not fully align with the UPS 797 guidelines for Low-Risk Level CSPs with 12-Hour of Less BUD. Recommend specifying the criteria for IS05 PECs that fall under this category. USP 797 guidelines allow for sterile compounding within a CAI or CACI that meets all of the operational criteria as defined in Section 1751.4(f) and use of beyond use dating specified in Sections 1751.8(a) and (b) corresponding to beyond use dating of Low-Risk Level CSPs and Medium-Risk Level CSPs.*

Code Section	Commenter	Comment
1751.8(d)(1)	Community Regional Medical Center Bruce Lepley, Director of Pharmacy	**Reason for Concern:** The most recent USP 797 regulations state that viable surface sampling be done periodically. Many hospitals conduct surface sampling every six months to coincide with the requirements for PEC and cleanroom certification. Pharmacies may also not have access to qualified individuals every month for surface sampling, but would have access to these qualified individuals every six months for the PEC and cleanroom certifications. **Solution:** Reduce the viable surface sampling requirement to every six months.
1751.8(d), (d)(1), (d)(3)	Douglas Barcon, Pharm.D., Barcon & Associates	Section (d)(1) specifies a segregated compounding area and (d)(3) specifies that the BUD cannot exceed 12 hours in the absence of passing a sterility test in a laminar air flow workbench or biological safety cabinet. This is addressed in USP 797. Section (d) addresses sterile compounding in a segregated compounding area with compounding manipulations in an ISO Class 5 PEC. It makes no reference to use of an ISO Class 5 compounding aseptic isolator or compounding aseptic containment isolator that is compliant with ISO Class 5 as specified in 1751.4 (f)(1), (f)(2), and (f)(3), and certified by the manufacturer as specified in 1751.4 (h) in a non-ISO rated room, which could include a segregated compounding area. Placement of a compliant and manufacturer certified CAI or CACI in any room, would permit the full USP 797 beyond use dates. Perhaps there should be a paragraph (4) added to 1751.8 (d) or a new lettered section should be added to address use of a CAI or CACI in a segregated compounding area or other closed room. A change such as this would address and eliminate the BUD issue in critical access hospitals where a pharmacist is not available to compound 24 hours per day. In the case of a trained and properly garbed non-pharmacist or non-pharmacy technician doing such compounding, such as a nurse, the preparations shall be limited to low-risk and the BUD should not exceed 24 hours when refrigerated. When I had an email dialog with Eric Kastango in late July, he too agreed that this would be an acceptable solution for critical access hospitals, and that it would be up to the state to draft such a regulation for critical access hospitals. If a new lettered section is added, the current (f) specifies (a) through (e), which would also need to be changed.
1751.8(d)(2)	California Pharmacist Association Brian Warren	the compounding process involves simple transfer of not more than three commercially manufactured packages of sterile nonhazardous preparations or diagnostic radiopharmaceutical preparations from the manufacturer's original containers**.~~; and~~**

Code Section	Commenter	Comment
1751.8(d)(3)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: "….the beyond use date shall specify that administration shall commence no longer than 12 hours after preparation. Rationale: It appears as though this language is attempting to describe the requirements of "Low-Risk Level CSPs with 12-Hour or Less BUD" in USP Chapter 797. The proposed language appears to require that the compounded drug preparation must be stored in a laminar air flow workbench or biological safety cabinet. This is incorrect.
1751.8(d)(3)	California Pharmacist Association Brian Warren	the compounding process involves not more than two entries into any one container or package (e.g., bag, vial) of sterile infusion solution or administration container/device**. ~~in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference, that would justify a more extended beyond use date, the beyond use date shall specify that storage and exposure periods cannot exceed 12 hours in a laminar air flow workbench or biological safety cabinet~~**
1751.8(d)(3)	California Society of Health-System Pharmacists Dawn Benton	Recommend changing language: ", the beyond use date shall specify "that administration shall begin no later than 12 hours after preparation". Rationale: The proposed language is confusing and ambiguous and not consistent with industry standards and appears to say that after preparation, a compounded drug must be stored in a laminar airflow workbench or biological safety cabinet.
1751.8(d)(3)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Recommend inserting the words "before administration is initiated" after the word "periods" to ensure that board regulations are more closely aligned with compounding standards in USP 37 <797> and the beyond use date definition being proposed in CCR 1735.1 (c). Recommend ending the sentence after the word "hours". The location of compounding is already specified in 1751.8(d)(1) and as proposed, the way it reads it is as if the preparation is being stored or exposed in the actual PEC; which I don't believe was intended.
1751.8(d)(3)	GrayMatter Pharmacy Services, Inc Michael Moore, R.Ph.	This would prevent our facility from even making "banana bags" for the staff. In a facility that is not 24 hours we will be depending on nursing to do more and more compounding of complicated products with multiple additives out on the floor. I fail to see how this would be in the best interest of public safety. It appears you are creating safety in one area at the expense of safety in another.
1751.8(d)-(f)	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	The BUD for nonhazardous products made within an ISO Class 5 PEC in a non-ISO classified room is 12 hours. The BUD for compounding a low volume (defined as 5 or less per week) of hazardous drugs is 12 hours. What is the BUD for compounding a higher volume of hazardous drugs if made in an ISO Class 5 laminar airflow hood in a non-ISO classified room – can it be set by the pharmacy?
1751.8(e)	California Pharmacist Association Brian Warren	**A beyond use date shall specify that storage and exposure periods cannot exceed 12 hours when ~~Where~~** the sterile compounded drug preparation was compounded **under both of the following conditions:**

Code Section	Commenter	Comment
1751.8(e)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	Low volume is not defined in any current national guidelines. Recommend deleting the low volume definition since (1) Moderate and high volume would no longer be addressed in the regulations, 2) There is no existing official definition of low volume chemo preparation and (3) new guidelines are pending from USP. delete
1751.8(e)	Douglas Barcon, Pharm.D., Barcon & Associates	This section does not specify the ISO class of the room for compounding hazardous drugs. This section addresses both low-volume and non-low-volume hazardous drug compounding, but does not fully differentiate between the two. It only addresses a non-negative pressure room, which could be an ISO rated room or a non-ISO rated room. The beyond use date for a hazardous drug could be longer than 12 hours depending on the room and the PEC. There should be a separation between a biological safety cabinet and a compounding aseptic containment isolator in this section because they are functionally different. If a compounding aseptic containment isolator is used for hazardous drugs and it has been tested to be compliant with ISO Class 5 as specified in 1751.4 (f)(1), (f)(2), and (f)(3), and certified by the manufacturer as specified in 1751.4 (h) for use in a non-ISO rated room, the beyond use date should be as specified per USP 797 and USP 800 for the respective risk level at any volume. If the compounding aseptic containment isolator for hazardous drug compounding is compliant with ISO Class 5, but is not certified by the manufacturer for use in a room with air quality worse than ISO Class 7, then the beyond use date cannot exceed 12 hours. Ideally, the CACI should be vented to the outside and venting to the outside will be required by USP 800. If the PEC is an ISO Class 5 biological safety cabinet located in a worse than ISO Class 7 room that is negative pressure or non-negative pressure, the BUD for such preparations should not exceed 12 hours as specified. Ideally, the BSC should be vented to the outside and venting to the outside will be required by USP 800. Note that USP 800 intends to eliminate the non-negative pressure room clause for hazardous drug compounding, regardless of whether the PEC is certified by the manufacturer to be compliant for hazardous drug compounding in a non-negative pressure room. USP 800 also intends to eliminate the low-volume exemption for hazardous drug compounding.
1751.8(e)(1)	California Pharmacist Association Brian Warren	Using or containing hazardous drugs or components**~~.; and~~**

Code Section	Commenter	Comment
1751.8(e)(2)	Sutter Health Jeannette Hanni	Current "in facilities that prepare a low volume of hazardous drugs, where low volume is defined as five or less per week, the use of two tiers of containment (eg closed system transfer device within a biological safety cabinet or compounding aseptic containment isolator that is located in a non-negative pressure room) Recommend deleting the low volume definition since: 1) Moderate and high volume would no longer be addressed in the regulations AND 2) There is no existing official definition of low volume chemo preparation. AND 3) New guidelines are pending from USP.
1751.8(e)(2)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: "using two tiers of containment (e.g., a closed system transfer device within a compounding aseptic isolator that meets the requirements delineated in 1751.4(f) that is located in a non-negative pressure room).may be assigned beyond use dates as specified in 1751.8 (a)(b)(c)." Rationale #1: Hazardous drugs prepared in a compounding aseptic containment isolator that meets the requirements delineated in 1751.4(f) may be assigned the Beyond Use Dates delineated in 1751.8 (a)(b)(c) Recommendation: We propose this definition for low volume: "A low volume is defined as less than or equal to a mean number of twenty doses per week, averaged over a period of one month." This would enable a hospital to treat a small number of patients requiring chemotherapy. Rationale #2: Patients who receive chemotherapy treatment in a hospital frequently receive multi-drug chemotherapy regimens. With the current definition of five or less preparations per week, it is unlikely that even one patient could be treated.
1751.8(e)(2)	California Society of Health-System Pharmacists Dawn Benton	Recommend deleting the low volume definition. Rationale: Moderate and high volume would no longer be addressed in the regulations, 2) There is no existing official definition of low volume chemo preparation and (3) new guidelines are pending from USP.
1751.8(e)(2)	California Pharmacist Association Brian Warren	In facilities that prepare a low volume of hazardous drugs, where low volume is defined as five or less per a week, the use of two tiers of containment (e.g., closed system transfer device within a biological safety cabinet or compounding aseptic containment isolator that is located in a non-negative pressure room)**. ~~the beyond use date shall specify that storage and exposure periods cannot exceed 12 hours.~~**
1751.8(e)(2)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	Recommend inserting the words "before administration is initiated" after the word "periods" to ensure that board regulations are more closely aligned with compounding standards in USP 37 <797> and the beyond use date definition being proposed in CCR 1735.1 (c).

Code Section	Commenter	Comment
1751.8(e)(2)	Community Regional Medical Center Bruce Lepley, Director of Pharmacy	**Reason for Concern:** The sentence is unclear how the preparation of low volume relates to the two tiers of containment (e.g. low volume and without two tiers of containment or low volume and with two tiers of containment). USP 797 does not have a section specific to this proposed language, nor does USP 800, limiting the beyond use date for hazardous drugs in a low volume facility to 12 hours or less. This may actually pose more of a risk for low volume facilities that must compound their hazardous drugs every 12 hours since they may not have the staff or resources to accomplish this frequency. **Solution:** Remove section (e) completely.
1751.8(e)(2)Page 34	Providence Heath & Services Southern California Region	Eliminate "low volume" in reference to the preparation of hazardous drugs. Each Providence pharmacy prepares, at a minim urn, an average of 25 doses per week for our most vulnerable patients. USP 797 guidelines do not define "low *volume,"* and we are uncertain how the board came to define "five or less per *week"* as a sufficient dosage. Hospital pharmacies should continue to compound sterile drug and hazardous drug preparations under specified conditions in the proposed regulations, without compromising patient health and safety.
1751.8(e),page34	Providence Heath & Services Southern California Region	Providence recommends removing 1751.8(e) and adding to section 1751.4(g): *Where the sterile compounded drug preparation was compounded (1) using or containing hazardous drugs or components; and* (2) in facilities that prepare a low volume of hazardous drugs, ~~where low volume is defined as five or less per a week~~, the use of two tiers of containment (e.g. closed system transfer device within a biological safety cabinet or compounding aseptic containment isolator that is located in a non-negative pressure room) the beyond use date shall specify that storage and exposure periods cannot exceed ~~12 hours~~ *those specified in accordance with the criteria listed in Sections 1751.8(a) through (c)* . Per USP 797, use of a closed system transfer device within a biological safety cabinet or CACI does not affect the determination of beyond-use dating. Negative or positive pressure of the room does not affect the determination of beyond-use dating; it only specifies the exposure risk of hazardous drugs to the environment The ISO Class air quality of the compounding conditions, compounding process and sterility of components determines the beyond-use dating. For example, compounding a sterile hazardous drug preparation in a negative pressure room that meets or exceeds IS07 buffer area quality within an ISOS PEC would be afforded a beyond-use date consistent with Low-Risk Level CSPs.
1751.8(f)	GrayMatter Pharmacy Services, Inc Michael Moore, R.Ph.	This labeling requirement will be almost impossible to monitor and enforce. Asking nursing to add an additional label to the products that they compound will be exceedingly difficult.
1751.8(f)	UCSD Research Pharmacy Leticia Muttera, Pharm. D	What about vaccines and IM antibiotics such as Rocephin 250mg IM x1 given in areas such as MD offices?

Code Section	Commenter	Comment
1751.8(f)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	delete
1751.8(f)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	If a facility were to compound a sterile hazardous preparation under conditions that meet all of the requirements of subdivisions (a) through (e) except (e)(2) where the volume of hazardous drugs prepared exceeds five or less be a week, I would interpret this to mean immediate use requirements in this subdivision (1751.8(f)) apply. If this is a correct interpretation, then I have grave concerns about this subdivision with respect to compounding of sterile hazardous preparations. If the only requirement of subdivisions (a) through (e) that cannot be met is the volume requirement it would unnecessarily impose immediate use requirements such as "complete administration is witnessed by the preparer" and "beginning of administration commencing within one hours following the start of the compounding process". Hazardous drug compounding typically involves redundant safety checks during the preparation process and depending on the type of preparation may require an hour or more for proper medication activation (e.g. use of microspheres for chemo-embolization). The commencement of the administration of compounded hazardous preparations is highly reliant upon other patient care factors such as pump set up and priming, patient education, the administration of pre-medications and possibly other competing priorities the nurse or caregiver administering the medication is balancing. The one-hour interval between commencing of compounding and administration would be challenging, possibly unsafe, costly and would not be warranted in situations where the only requirement of the subdivision unmet is the volume of hazardous drug preparation. In addition, in this specific circumstance, having the preparer, commonly a Pharmacy Technician or in some cases a Pharmacist witness the administration does not reasonably offer a benefit to patient care it would only add costly labor resources especially with the hazardous drugs continuously infused over a 24 hour period.
1751.8(f)	Kaweah Delta Medical Center Rheta Sandoval, Pharm.D.	To remedy this concern, language proposed in section 1751.8(f) could be modified from "for any of subdivisions (a) through (e)" to "for any of subdivisions (a) through (d). Alternatively, consider adding a section that would cover facilities that are compounding hazardous drug preparations in an ISO Class 5 PEC within a ISO Class 7 buffer area using two tiers of containment within a biological safety cabinet or compounding aseptic containment isolator (located in a non-negative pressure room) BUT are compounding volumes in excess of five per week.

Code Section	Commenter	Comment
1751.8(f)	California Pharmacist Association Brian Warren	**(1)** Where any sterile compounded drug preparation was compounded either outside of an ISO class 5 PEC or under conditions that do not meet all of the requirements for any of subdivisions (a) through (e), the sterile compounded drug preparation shall be labeled " for immediate use only" and administration shall begin no later than one hour following the start of the compounding process. Unless the " immediate use" preparation is immediately and completely administered by the person who prepared it or immediate and complete administration is witnessed by the preparer, the preparation shall bear a label listing patient identification information, the names and amounts of all ingredients, the name or initials of the person who prepared the compounded sterile preparation, and the exact one-hour beyond use date and time. If administration has not begun within one hour following the start of the compounding process, the compounded sterile preparation shall be promptly, properly, entirely, and safely discarded. This provision does not preclude the use of a PEC to compound an "immediate use" preparation. **(2)** Such "immediate use" preparations shall be compounded only in those limited situations where there is a need for immediate administration of a sterile preparation compounded outside of an ISO class 5 environment and where failure to administer could result in loss of life or intense suffering. Any such compounding shall be only in such quantity as is necessary to meet the immediate need and the circumstance causing the immediate need shall be documented in accordance with policies and procedures.
1751.9	Unknown Speaker at Hearing	Reconsider limits of use of single use vials and multiple use vial and end dates.
1751.9	Hartley Medical, William Stuart	a. Comments: I have had many concerns regarding time limitations associated with single dose or multi-dose vials as they relate directly to sterile compounding of preparations. Numerous studies have been conducted regarding contamination rates of single-dose or multi-dose vials within healthcare institutions. In these studies, which were performed in hospital settings, the vials in use were on hospital floors. These studies were very useful in understanding contamination rates of vials utilized on the hospital ward. However, this environment is extremely different than that of an ISO 5 environment or better. I have been unable to locate any published studies of single-dose or multi-dose vial contamination rates within ISO 5 environment. The sterile preparation area for which the primary engineering control devices are located are designed to provide a more optimal environment for sterile compounding. Lastly, I spent over six years studying potential contamination of multi-dose vials utilized in an ISO Class 5 LAFW within my institution. We obtained samples from multiple use vials (approximately 50% utilized) and inoculated two types of growth medium and incubated for 14 days. Next, we removed the same vials (approximately 10% remaining fluid) from which the original samples were derived, and we aseptically fill each vial with growth media and incubated for another 14 days. As of this date we have yet to observe microbial growth. b. Recommendation: Please reconsider removing beyond use dates for single dose and multi-dose vials utilized in sterile compounding.

Code Section	Commenter	Comment
1751.9(a), (b), and (c)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: Include above language from USP 797 allowing the use of proven technologies with quality assurance procedures (for example, Closed System Transfer Devices) allowing for extension of BUD for single-dose vials. Rationale: One of the hallmarks of USP and Current Good Manufacturing Practices (cGMP) is the ability of entities under the guidelines to be innovative and advance practice with validated processes that differ from the current standards. The advancement of knowledge, technology, and validation processes in a very fluid environment must be allowed to flourish; thus the ability to design programs that meet or exceed current outcomes is essential. The key statement allowing this within the USP 797 is as follows: “The use of technologies, techniques, materials, and procedures other than those described in this chapter is not prohibited so long as they have been proven to be equivalent or superior with statistical significance to those described herein”
1751.9(a)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	delete
1751.9(b)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	delete
1751.9(b)	Cedars-Sinai Katherine Palmer Rita Shane	Cancer drugs have been associated with multiple drug shortages and adverse patient outcomes. One research study determined that substitution with cyclophosphamide for mechlorethamine resulted in significantly less efficacy in treatment of children with Hodgkin's lymphoma. Additionally, as a result, counterfeit chemotherapy is an area of national concern,until such time as E-Pedigree is available. Closed system transfer devices (CTSD) protect the vial from entry of external bacteria after initial puncture beyond the USP 797 approved 6 hour time limit. It has been shown that one of these systems maintains sterility of the vials to which it is attached for up to 168 hours (7 days). Recommendation: Allow use of CTSDs with supporting literature to extend the beyond use date of single dose vials of chemotherapy to 24 hours or use through the end of the shift whichever is shorter. This recommendation is more conservative than the timeframe of 7 days listed in the CTSD study and would assist institutions in conserving scarce chemotherapy medications.

Code Section	Commenter	Comment
1752	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend deletion of 1752 entirely. Rationale: 1) Beyond the authority of the Board of Pharmacy to dictate the type of personnel that may deliver medication. 2) It should be left to the professional judgment of a pharmacist to determine the delivery methodology based on the patient's need in each individual situation.
1752	California Society of Health-System Pharmacists Dawn Benton	Recommend deletion of 1752 entirely. Rationale: 1) Beyond the authority of the Board of Pharmacy to dictate the type of personnel that may deliver medication. 2) It should be left to the professional judgment of a pharmacist to determine the delivery methodology based on the patient's need in each individual situation.
1753(b)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	For "(b)" Recommend deleting renumbering of 1751.1.1 from this regulatory proposal and considering updating those provisions in a future regulation revisions proposal. Rationale: This is an outdated drug list.
1753(b)	California Society of Health-System Pharmacists Dawn Benton	Recommend deleting renumbering of 1751.1.1 from this regulatory proposal and considering updating those provisions in future revisions proposal. Rationale: This is an outdated drug list.
1753(b)	BJ Bartleson, RN, MS, NEA-BC California Hospital Association	Recommend review and revision of medication listed in this section
1753(c)	California Society of Health-System Pharmacists Dawn Benton	Recommend modifying language to "Have a specific treatment protocol "or order" from a prescriber for the administration of each medication contained in the portable container." Rationale: A prescriber should be able to order a drug that is in the portable container for a use that is different than specified in the facility's protocol for that drug.
1753(c)(1)(C)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend modifying language to "Have a specific treatment protocol "or order" from a prescriber for the administration of each medication contained in the portable container." Rationale: A prescriber should be able to order a drug that is in the portable container for a use that is different than specified in the facility's protocol for that drug.
1753(e)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommend this section be reviewed based on current practice (use of electronic health records). Rationale: This section does not consider current practice such as the use of electronic health records and drug classifications. This section appears to be beyond the authority of the Board to dictate procedures in home health agencies and hospices.

Code Section	Commenter	Comment
1753(e)	California Society of Health-System Pharmacists Dawn Benton	Recommend this section be reviewed based on current practice (use of electronic health records). Rationale: This section does not consider current practice such as the use of electronic health records and drug classifications. This section appears to be beyond the authority of the Board to dictate procedures in home health agencies and hospices.
1754	California Society of Health-System Pharmacists Dawn Benton	Recommendation, if 1751.11 is updated by this regulation change proposal, then the reference numbering in 1754 (a) and (b) should be revised.
General Comment (No Code Section)		
	GrayMatter Pharmacy Services, Inc Michael Moore, R.Ph.	Please consider that much of what has been proposed is valuable, but it is an unreasonable expectation of all pharmacies to comply with every rule proposed. I strongly believe that these regulations will push the burden of compounding to the nursing staff. This is neither safe nor efficient. If the goal of the State Board of Pharmacy is to "protect the public" then I would argue that some of the language within these new regs will result in unintended consequences. I hope that the state board will step forward and accept some of the responsibility when an error is committed by nurses that are forced to compound medications for patients.
	Charles A. Reynolds, Pharm.D., B.C.P.P UCLA Health System	We would like to point out that bedside sterile administration by nursing (while not regulated by the Board) was decided years ago by both Centers for Medicare & Medical Services and The Joint Commission to be an unacceptable practice except in the treatment of true acute emergencies. We would also point out that the literature documents the safety of the practice of compounding within a certified ISO Class 5 biological hood (vertical or horizontal flow) as well as the decreased risk to the patient of such compounding in relation to bedside compounding. As such it appears to us that the current proposed regulations treat all compounding areas as under the same rules [i.e. USP 797 (and future versions) compliance] and will therefore force all compounding into a central area which will not be able to address the immediate needs of the hospitalized patient. This will then return clinical care to bedside administration and/or delays in patient care within California. It will also open decentralized pharmacy sites to financial pressures to terminate such practices, which is also not in the best interest of California patients. Finally, we would like to point out that for the most part the compounding violations that the Board has been recently citing involve preparations that are being made for future use. It is the storage of these compounded products that has caused any breach of aseptic technique to become clinically significant. This too points to the need to address compounded sterile products for immediate administration differently than compounded sterile products for future use

Code Section	Commenter	Comment
	McGuff Compounding Pharmacy Services, Inc William J. Blair, Pharm.D., MBA Vice President and Director of Pharmacy Services	In general, California Law and regulation should harmonize with the federal description of a drug that has been compounded, i.e. “Compounded Drug” or Compounded Drug Product”. (503A and 503B). This harmonization identifies that the finished product of compounding via prescription or order is a drug, with full recognition as a drug in federal law and regulation. To use words like ‘compounded preparation’ adds confusion to the market place and allows insurance companies to classify Compounded Drugs as something other than a drug. This also adds confusion to the media which may likely lead the media to mis-manage or mis-identify the regulatory environment in which these Compounded Drugs are made. “Preparation’ may also confuse patients as ‘preparation’ may not connote the same gravity as taking a drug.
Overall Recommendations (No Code Section)	Providence Heath & Services Southern California Region	Use existing best practices to support best quality outcomes: We urge the board to adopt regulations that reflect the best quality outcomes, and to codify the measures implemented by hospital pharmacies, as documented here, that already are protecting patient safety and are aligned with USP Chapter 797 guidelines. Provide enough time for compliance: The board should extend the timeframe for implementation and enforcement of the final rule to ensure hospital pharmacies are fully compliant with state building regulations and hospital licensure requirements, particularly if facility changes and construction are to be completed
Acute Care Recommendations (No Code Section)	Providence Heath & Services Southern California Region	Avoid unnecessary definitions: Eliminate "low volume" in reference to the preparation of hazardous drugs in hospital pharmacies. Under this definition, Providence pharmacies will not be able to prepare life-saving therapies to patients, including chemotherapy, antiviral, and anti-rejection treatments. USP 797 guidelines do not define "low volume," and we are uncertain how the board came to define "five or less per week" as a sufficient dosage. Hospital pharmacies should continue to compound sterile drug and hazardous drug preparations under specified conditions in the proposed regulations, without compromising patient health and safety. Provide flexibility in location: Remove wording from the beyond use dating sections that require an ISO Class 5 PEC to be located in an ISO Class 7 buffer area with an ante-area. USP 797 allows for the specified beyond use dating to apply to low and medium risk level compounding performed within an operationally compliant CAI or CACI located outside of an ISO class 7 buffer area. Without the recommended changes, hospital pharmacies will be prevented from utilizing USP 797 beyond use dating when compounding within the guidelines using a CAI or CACI in a non-ISO Class 7 cleanroom.
Add new section to Article 4.5, Division 17 of Title 16 of CCR	PharMEDium Services, LLC Rich Kruzynski	An entity may provide for human use, without a patient specific prescription, a non-patient specific sterile compounded drug preparation if the following conditions apply: (a) The entity is registered with the United States Food and Drug Administration as an outsourcing facility pursuant to section 503B of the Federal Food, Drug, and Cosmetic Act; and (b) The entity is licensed as a Sterile Compounding Facility with the California Board of Pharmacy.
Comments outside of Scope of Regulation		

Code Section	Commenter	Comment
4127.1	PharMEDium Services, LLC Rich Kruzynski	(a) A pharmacy shall not compound sterile drug products unless the pharmacy has obtained a sterile compounding pharmacy license from the board pursuant to this section. The license shall be renewed annually and is not transferable. (b) A license to compound sterile drug products shall be issued only to a location that is licensed as a pharmacy with the Board of Pharmacy or as a Human Drug Compounding Outsourcing Facility under Section 503B of the Federal Food, Drug and Cosmetic Act, and shall be issued only to the owner of the pharmacy or Outsourcing Facility licensed at that location.
1707.5(a)(4)(A-P)	Kaweah Delta Home Infusion Pharmacy Steven Schnitzler, Pharm D.	*When applicable, directions for use shall use one of the following phrases:….* Route of administration is not included in any of the recommended phrases – may want to add [insert appropriate route] to avoid confusion.
Title 24, Part 2 Chapter 12 1250.4(5)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Add the displacement airflow design as an acceptable alternative design. In this design there is no physical door (and pressure differentials) between the buffer and the ante-area. The displacement airflow design is described in USP Chapter 797: "For rooms providing a physical separation through the use of walls, doors, and pass-throughs, a minimum differential positive pressure of 0.02- to 0.05-inch water column is required. For buffer areas not physically separated from the ante-areas, the principle of displacement airflow shall be employed. This concept utilizes a low pressure differential, high airflow principle. Using displacement airflow typically requires an air velocity of 40 ft per minute or more from the buffer area across the line of demarcation into the ante-area." This type of cleanroom design was added to the definition of "cleanroom" in Section 1735.1, but was not added to the text of this regulation. Rationale: USP Chapter 797 articulates a well thought-out description of the sterile compounding environment and engineering controls, based on the input and experience of nationally respected clean room engineers.
Title 24, Part 2 Chapter 12 1250.4(5.3)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Recommendation: Change regulation to say "…..in an environment that is less clean than ISO Class 7 Concern: Ambiguous wording RE: exceeds ISO Class 7, e.g. does that mean cleaner than ISO Class 7, or less clean than ISO Class 7?

Code Section	Commenter	Comment
Title 24, Part 2 Chapter 12 1250.4(6)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Concern #1: There is a need to clarify the exact requirements outlined in this Regulation. Two documents have been shared with the public appear to conflict with each other; The first document discusses the need for a negative pressure room for compounding hazardous drugs. The second document also describes the compounding of hazardous drugs in a positive pressure room. To be in concordance with USP Chapter 797, there needs to be an allowance for compounding a low volume of chemotherapy preparations within biological safety cabinets (utilizing closed system transfer devices) in positive pressure clean rooms that also contain other types of laminar air flow hoods. Consider a hospital pharmacy in which a low volume of inpatient chemotherapy is prepared, and where the clean room was remodeled following the original 2004 USP Chapter 797 standards. It would likely be a single clean room, with an ante area and a buffer area. That remodel probably cost up to $1 million, depending upon the size of the pharmacy. In order to meet the proposed regulation, this clean room would need to be remodeled again to provide a separate anteroom, positive pressure buffer room, and a negative pressure buffer room for preparing hazardous drugs (chemotherapy). This would cost approx. an additional $1 million per inpatient pharmacy. The cost is excessive when weighed against any potential incremental patient safety benefits. The current language also conflicts with another section of the draft language, 1751.8(e)(2). Instead, we propose the USP Chapter 797 language, with a caveat that “low volume” be defined, since the USP Chapter 797 language is subjective and not enforceable. “In facilities that prepare a low volume of hazardous drugs, the use of two tiers of containment (e.g., Closed System Transfer Device within a BSC or CACI that is located in a non-negative pressure room) is acceptable.” We propose this definition: “A low volume is defined as less than or equal to a mean number of twenty doses per week, averaged over a period of one month.”
Title 24, Part 2 Chapter 12 1250.4(6)	Kaiser Permanente Steven Gray Doug O'Brien Don Kaplan	Concern #2: There needs to be an allowance for ambulatory/outpatient oncology pharmacies which do not currently meet this requirement, and prepare a high volume of chemotherapy (e.g. greater than twenty doses per week) for administration to patients in medical offices and clinics. These pharmacies are typically equipped with a Class II biological safety cabinet in a small ISO Class 7 clean room under positive pressure. It will be very costly and time-consuming to remodel these pharmacies. We propose that ambulatory/outpatient oncology pharmacies be given a five-year period to come into compliance with the negative pressure environment requirement.

Attachment 2

Code Section	Commenter	Comment
1735-1754	**University Compounding Pharmacy** Joe Grasela	There should be a section to define methods of sterilization and integrity testing to validate that the compounded preparation is sterile or validate that the process of sterilization is correct (ie: Use of “spore testing” when sterilization is performed with an autoclave) According to USP <1211>, sterile solid dosage forms (ie: Pellets) should be sterilized by gamma irradiation.
1735	**California Hospital Association** BJ Bartleson	Add to section (a) a new addition in italics, (5) which states, “*Adding a manufacturer vial to a commercial infusion solution except when part of a proprietary transfer device* ” as many hospitals misinterpret the exemptions in the aforementioned 1735.(4) to exclude simple admixture
1735.1(a)	**University Compounding Pharmacy** Joe Grasela	“Ante-area” means an area providing at least an ISO Class 8 or better air quality where personnel hand hygiene and garbing procedures, staging of components, and other high-particulate-generating activities are performed, that is adjacent to the area designated for sterile compounding. It is a transition area that begins the systematic reduction of particles, prevents large fluctuations in air temperature and pressures in the buffer area, and maintains air flows from clean to dirty areas. Please define “staging of components” in the ante area. Does that include “presterilization procedures?” Per USP 797 under section “Placement of Primary Engineering Controls”-”Pre-sterilization procedures for high-risk level CSPs, such as weighing and mixing, shall be completed in no worse than an ISO Class 8 environment.” Location of presterilization procedures should be defined per USP 797 guidelines.
1735.1(b)	**Kaweah Delta Medical Center** Rheta Sandoval	Once dispensed, the pharmacist may not have control of storage of the preparation after dispensing, for example in the case of furnishing to a prescriber. Please consider inserting the words “in the pharmacy” immediately before the words “(other than for quarantine purposes). I recognize that this is not consistent with USP’s definition and don’t have any other suggestions for how to resolve the concern except to perhaps clarify in a FAQ.
1735.1(c)	**Barcon & Associates** Douglas Barcon	HEPA was not defined as a separate definition. The acronym of HEPA in this paragraph is defined incorrectly. HEPA means High-Efficiency Particulate Air. Recommendation: Replace “hiqh-efficiency particulate absorption (HEPA)” with “high-efficiency particulate air (HEPA)”
1735.1(e)	**Pacific Compounding Pharmacy** Marie Cottman	Comments: The term "manufacturing" is inappropriate for reference to compounded drug product Recommendation: Change "manufacturing" to "preparation" which is consistent with a Compounded Drug Preparation
1735.1(f)	**Pioneers Memorial** John Teague	it seems to me that it mirrors (e) but some of the grammar is missing “ISO 7 or better air quality” and “(PEC) is physically” which is how its written in (e)

Code Section	Commenter	Comment
1735.1(f)	**Kaweah Delta Medical Center** Rheta Sandoval	Concerned about the language “for hazardous compounds, or for chemotherapy compounds”. To not permit the displacement concept to maintain clean room area requirements will have significant impact for some facilities in terms of remodeling and construction costs. Outside of the costs and time necessary to complete facility modifications to meet this requirement, there could be negative impacts if a pharmacy could not continue to provide the potentially life-saving “hazardous” medications needed as a facility works towards gaining compliance with the requirement. Some geographic areas of the State may not have a nearby health facility to provide this type of service or the ability to handle the order volume currently managed by the Pharmacy. Understanding a key element of proposed USP <800> is to require that hazardous drugs be stored in a negative or normal/pressure, and compounding must be completed in certified biological safety cabinets or compounding aseptic containment isolators in a separate room with negative pressure attempts to align State with Federal Standards may be indicated. However, if the BOP adopts the modified text as proposed and there are not reasonable timelines and expectations for compliance established, it could severely limit patient access to needed care or place tremendous burdens on patients and those supporting their care to travel to a facility that is compliant with the regulation. Consider deleting the language “for hazardous compounds, or for chemotherapy compounds” and possibly reintroducing at a later time after fully assessing impacts to Pharmacies holding Sterile Compounding Licenses in this state and establishing reasonable timelines for gaining compliance.
1735.1(f)	**Cedars-Sinai** Katherine Palmer Rita Shane	For buffer areas not physically separated from the ante-areas, the principle of displacement airflow shall be employed. This concept utilizes a low pressure differential, high airflow principle. Using displacement airflow typically requires an air velocity of 40ft per minute or more from the buffer area across the line of demarcation into the ante- area. The displacement concept may not be used for to maintain cleanroom area requirements for sterile compounds which originated with non-sterile-to-sterile batch, with any ingredient that was at any time non- sterile, regardless of intervening sterilization of that ingredient ~~for hazardous compounds, or for chemotherapy compounds~~. In the absence of a physically separated buffer and ante area for medication preparation, USP 797 allows the use of displacement airflow. Application of this to hazardous drug areas is essential for organizations that don't have a separate room to allow for hazardous medication preparation for cancer patients.
1735.1(f)	**Mercy General Hospital** Jeffrey Nehira	This definition should state, "Cleanroom or buffer area" in the definition as clean room is not synonym’s to buffer area.

Code Section	Commenter	Comment
1735.1(f)	**Barcon & Associates** Douglas Barcon, Pharm.D	The proposed definition of cleanroom does not meet the dictionary definition of a room or the common understanding of room because walls are not mandatory to create a separate area. An area without walls designated for sterile compounding would be a segregated sterile compounding area, not a cleanroom. Displacement airflow cannot provide an effective barrier on all sides to separate an uncontrolled, non-ISO class area, such as a pharmacy, hallway, or warehouse from a controlled area. Displacement airflow cannot provide an effective barrier from an ante-area, ISO Class 7 buffer area, or ISO Class 5 PEC if there are no physical walls or barriers (such as plastic sheeting) surrounding the entire cleanroom complex to contain and segregate the air from the surrounding non-controlled environment. The larger the opening between an ISO Class 8 ante-area and an ISO Class 7 buffer area, the more difficult it is to maintain effective separation with displacement airflow. Pressure differentials cannot be maintained if there are no walls or physical barriers. High-velocity air curtains or air knives cannot effectively be used in lieu of walls to create a cleanroom. Walls or physical barriers are necessary. A door is a physical barrier. This has been discussed with USP, members of the USP Compounding Expert Committee, and certifiers. New text is underlined in the next comment. Rather than revert to the October 2014 definition of cleanroom or the whole current USP 797 definition with appendices, which are options, the following two alternatives are suggested changes plus the remaining proposed text along with the addition of “physical barriers” in the second sentence that follows the alternatives:

Code Section	Commenter	Comment
1735.1(f) (Continued)	**Barcon & Associates** Douglas Barcon, Pharm.D	Alternative 1: "Cleanroom" (which may also be referred to as a buffer area) means a room with walls or physical barriers that provides segregation from the non-controlled environment and at least ISO Class 7 air quality where the primary engineering control (PEC) is located. Alternative 2: "Cleanroom" (which may also be referred to as a buffer area) means a room in which the concentration of airborne particles is controlled to meet and maintain at least ISO Class 7 conditions and shall be segregated by walls or physical barriers from surrounding, unclassified spaces to reduce the risk of contaminants being blown, dragged, or otherwise introduced into the filtered ISO Class 5 unidirectional airflow environment PEC. The cleanroom may maintain segregation from the adjacent ante-area by means of specific pressure differentials. For cleanrooms providing a physical separation through the use of walls, physical barriers, doors, and pass-throughs, a minimum differential positive pressure of 0.02- to 0.05-inch water column is required. For buffer areas not physically separated from the ante-areas, the principle of displacement airflow shall be employed. This concept utilizes a low pressure differential, high airflow principle. Using displacement airflow typically requires an air velocity of 40 ft per minute or more from the buffer area across the line of demarcation into the ante-area. The displacement concept may not be used to maintain cleanroom area requirements for sterile compounds which originated with non-sterile-to-sterile batch, with any ingredient that was at any time non-sterile, regardless of intervening sterilization of that ingredient, for hazardous compounds, or for chemotherapy compounds.
1735.1(g)	**Pioneers Memorial** John Teague	should also describe that a timeout during purge must be observed in the CAI or CACI doesn't have a continuous ISO5 environment in the pass through or transfer chamber which I liken to a sort of ante-chamber (basically the pass through window).
1735.1(h)	**Pioneers Memorial** John Teague	doesn't recognize that there are CACI systems that can be set to recirculate mode that do not require venting to the outside air as validated by the manufacturer. What also needs to be noted is what drugs are considered volatile as volatile drugs cannot be compounded in a recirculating self-contained unit, they require 100% venting to the outside
1735.1(k)	**Kaweah Delta Medical Center** Rheta Sandoval, Pharm.D.	The proposed definition encompasses the usual and customary working environment of 20 degrees to 25 degrees C (68 degrees to 77 degrees F) but USP General Notice 10.30.40 allows for transient excursions between 15 degrees C and 30 degrees C (59 degrees to 86 degrees F). Consider aligning with the USP General Notice.

Code Section	Commenter	Comment
1735.1(l)	**University Compounding Pharmacy** Joe Grasela	The term “essentially a copy” is vague and should be removed or clarify “essentially a copy”. Does that mean “exact dose with the same exact excipients” or “exact dose regardless of different excipients?” Define “significant difference” as determined by a prescribing practitioner. What qualifies a “significant difference?” Allergy or intolerance, or a high cost commercial drug that by not taking the medication would jeopardize a patient's quality of life? Define what qualifies a “significant difference.” We have patients that have allergies or are intolerant to bases/fillers that are provided in the commercially available product therefore a compounded preparation may be more suitable. Can the same active ingredients be used in a compounded preparation but have different strengths than the commercially available product? (ie: different strength, different dosage form, different excipients due to allergens, removal of dyes or preservatives (due to allergens), or the drug is currently on back order or shortage situation at which point disruption in therapy would be detrimental to the patient). Clarification is needed.
1735.1(l)	**Precision Pharmacy** Rachel Taggs	What does “comparable in active ingredients” mean? Does this mean the same active ingredient with same/similar strength?
1735.1(n)	**Precision Pharmacy** Rachel Taggs	The definition as stated would depend on the “patient” it is being used on. For example, if a dog and a horse are both given the same medication, a dog would need a different “dosage unit” than a horse. Please clarify if a single “container” containing one dose (for any patient) means the same as a “dosage unit”?
1735.1(q)	**Mercy General Hospital** Jeffrey Nehira	Recommend removing "…at a temperature and for a time period conductive to multiplication of microorganisms," since laboatory testing already defines appropriate incubation parameters.
1735.1(r)	**Pioneers Memorial** John Teague	NIOSH now defines hazardous drugs in 3 classes which should be properly recognized this came out a few months ago. Also much later you define any product made in a unit that compounds hazardous drug hazardous and must be labeled hazardous so this should be noted

Code Section	Commenter	Comment
1735.1(r)	**Barcon & Associates** Douglas Barcon, Pharm.D	Rationale: The proposed definition of hazardous is too narrow and relies heavily on the knowledge of the pharmacist-in-charge without guidance. NIOSH has revised the ASHP 1990 definition of hazardous drugs and published the revised definition in the NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, 2014. Drugs considered hazard¬ous include those that exhibit one or more of the following six characteristics in humans or animals: Carcinogenicity, Teratogenicity or other developmental toxicity, Reproductive toxicity, Organ toxicity at low doses, Genotoxicity, Structure and toxicity profiles of new drugs that mimic existing drugs determined hazardous by the above criteria. Recommendation: Change definition to: "Hazardous" means all anti-neoplastic agents and drugs that exhibit carcinogenicity, teratogenicity or other developmental toxicity, reproductive toxicity, organ toxicity at low doses, genotoxicity, and structure and toxicity profiles of new drugs that mimic existing drugs determined hazardous by these criteria as identified by the National Institute for Occupational Safety and Health (NIOSH) and any other drugs, compounds, or materials identified as hazardous by the pharmacist-in-charge.
1735.1(r)	**John Cronin**	The Board's effort to reference "hazardous" drugs instead of the language in the current regulations is to be applauded. However, the proposed language, as drafted, is confusing and misleading. A significant revision of this definition is required. Alternate language is proposed below. The National Institute for Occupational Safety and Health (NIOSH) is the U.S. federal agency responsible for conducting research and making recommendations for the prevention of work- related injury and illness. NIOSH is part of the Centers for Disease Control and Prevention (CDC) within the U.S. Department of Health and Human Services. It is not part of the Food and Drug Administration (FDA) which is responsible for the approval of drugs. NIOSH is not responsible for the therapeutic classification of drugs. NIOSH publishes a List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings. The latest version is dated 2014. NIOSH regularly reviews drugs for addition to or deletion from this list. The publication includes a review of the criteria used by NIOSH and others in identifying which drugs are classified as "hazardous." A review of the publication finds that not all anti- neoplastic agents have the characteristics necessary to be classified as "hazardous." A plain reading of the proposed definition cites NIOSH as the determinative agency for identification of which drugs are classified as "anti-neoplastic agents." As noted above, this is not one of the roles of NIOSH. The language also implies at all anti-neoplastic drugs are considered to be hazardous, which is contrary to fact and the findings of NIOSH. The definition needs to be revised to reflect the proper role played by NIOSH and to distinguish anti-neoplastic agents and other products identified by NIOSH as meeting their criteria for classification as "hazardous" from those that do not.

Code Section	Commenter	Comment
1735.1(r) Continued	**John Cronin**	A prime example is the drug Bevacizumab (trade name Avastin), which is approved to treat several types of cancer, but which is also widely used off-label to treat macular degeneration. Bevacizumab has a mechanism of action that is different from many other anti-neoplastic agents and presents a significantly different safety profile that those agents. In 2012, bevacizumab was among a list of drugs considered for addition to the NIOSH Hazardous Drug List. Upon review, NIOSH concluded that bevacizumab would not be included because it does not meet the criteria of a hazardous drug. Under the definition proposed in the revised regulation, bevacizumab would be defined as "hazardous" by the Board because it is identified as an anti-neoplastic agent by NIOSH, even though NIOSH has determined that the drug does not meet the criteria to be considered "hazardous." Language that results in this type of inconsistent finding needs to be corrected. I suggest the definition be amended to read: (r) "Hazardous" means all anti-neoplastic agents as drugs identified determined by the National Institute for Occupational Safety and Health (NIOSH) as meeting the criteria for a hazardous drug and any other drugs, compounds, or materials identified as hazardous by the pharmacist-in-charge. This amendment properly reflects the role of NIOSH, more accurately reflects the content of the List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings and allows the pharmacist-in-charge to include additional drugs and other substances that should be handled as hazardous.
1735.1(t)	**Pioneers Memorial** John Teague	a batch shouldn't include a compound preparation of one (1), this could negatively impact patient care if you are unable to supply an emergent request because you're required to quarantine a lot or batch for testing
1735.1(t)	**Cedars-Sinai** Katherine Palmer Rita Shane	"Lot" means ~~one or more~~ **greater than one dose of compounded drug preparation prepared in anticipation of immediate patient care needs** ~~compounded drug preparation(s) prepared during one uninterrupted continuous cycle of compounding from one or more common active ingredient(s)~~**.**
1735.1(t)	**California Hospital Association** BJ Bartleson	Add to section (t) the following italicized item, so it reads, "Lot" means one or more compounded drug preparation(s) prepared during one uninterrupted continuous cycle of compounding from one or more active ingredients. *It does not mean one or more compounded drug preparations prepared for specific patients in a hospital intended for use within the standard BUD* . The rationale is that when hospitals prepare drugs for patients, this is done in a "batch" with multiple patients receiving the same drug. The "lot" requirements should not apply to these patient specific drugs

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1735.1(t)	**California Society of Health-System Pharmacists** Dawn Benton	Recommendation: Increase clarity regarding “lot”. For example, “products made in anticipation of use and not labeled for specific patients at the time of compounding”
1735.1(t)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	The wording of this definition is confusing and requires clarification. We believe “lot” could be interpreted two different ways. 1. It could be interpreted to include different types of preparations that are prepared during one uninterrupted continuous cycle of compounding. A typical example of this interpretation in a hospital pharmacy: compounding four doses of azithromycin 500 mg/250mL dextrose 5% for four different patients, and two doses of famotidine 40 mg in 250mL dextrose 5% 250mL for one patient, and five doses of furosemide 100mg/100mL dextrose 5% for five different patients. All of these would be prepared in an uninterrupted continuous cycle of compounding. If the above example is the intended interpretation, then we recommend this language: “Lot” means one or more different compounded drug preparation(s) prepared during one uninterrupted continuous cycle of compounding from one or more common active ingredient(s).” 2. It could be interpreted to mean a single type of drug preparation compounded during one uninterrupted continuous cycle of compounding from one or more common active ingredient(s). Using the example above, four doses of azithromycin 500 mg/250mL dextrose 5% for four different patients would be considered one lot. If interpretation #2 is correct, then we recommend this language: “Lot” means a single type of drug preparation(s) prepared during one uninterrupted continuous cycle of compounding from one or more common active ingredient(s).” If interpretation #2 is correct, please see our comments regarding 1751.4 (d)(2).
1735.1(v)	**Pioneers Memorial** John Teague	a batch shouldn’t include a compound preparation of one (1), this could negatively impact patient care if you are unable to supply an emergent request because you’re required to quarantine a lot or batch for testing

Code Section	Commenter	Comment
1735.1(v)	**Key Compounding** Rachael Vardeman	I would also like to comment on the need to modify the definition of the word “batch” concerning sterile preparations for inhalation products, it is unrealistic as regards actual patient care, to limit the patient to “one” unit. Most sterile preparations for inhalation have 30-60 day expiration dates, the way “batch” is defined will force quarantine on a product that initially has a short expiration date. For example, a sterile inhalation preparation for a patient has directions that says 4ml BID and the preparation is placed in 4ml vials, you would need to dispense #240ml which equals 60 individual vials for a one month supply, if the preparation has a 60 day expiration, it will not have the full 30 days shelf life left when finally out of quarantine. This is true whether a patient is picking up or having the medication shipped. Facilities for testing are already backing up due to the new regulations, and while the growth period is 14 days, you can never be sure what place in line your product will have before the facility can release the preparation
1735.1(v)	**Harbor Compounding Pharmacy** Mai Tran Sam Kitahara	If this definition of batch applies, then a patient who receives one batch of a drug that needs to be dispensed in several single dose vials will have to wait 14 days for sterility testing and potency testing before they can receive their medications. For example, patients receive prescriptions for nebulized antibiotics or glutathione treatments for a duration of 1 or 2 weeks. Thus, the patient, in this dire situation, cannot receive their compounded sterile nebulizing treatment until after a period of 14 days after the compounded preparation has passed sterility testing and potency testing. This is also prohibitive because some nebulizing solutions, after the compounded date, expires after 14 days. Performing sterility and endotoxin test for non-batches are cost prohibited. Especially for uncommon strengths that is very patient specific and will not be used for anyone else. The premises of compounding is to fit the unique need of the patient and by defining batch as 1 or more will make these types of preparations very unaffordable and unavailable for patients. This will create unnecessary burden for a pharmacy that has a proven track record for compounding high risk preparation successfully. “Non-sterile-to-sterile batch” means compounding of any compounded drug preparation containing two (2) or more dosage units with any ingredient that was at any time non-sterile. Or “Non-sterile-to-sterile batch” means a sterile preparation compounded from one or more non-sterile ingredients in a supply that will be used on more than one dispensing to a patient or patients or any sterile preparation compounded in excess of the filling of an individual prescription.

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1735.1(v)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Recommend changing the number of dosage units to 25 to be in concordance with National Standards. Rationale: The "Batch" definition from USP Chapter 797 applies only to "All high-risk level CSPs that are prepared in groups of more than 25 identical individual single-dose packages (e.g., ampules, bags, syringes, vials) or in multiple-dose vials (MDVs) for administration to multiple patients or that are exposed longer than 12 hours at 2 degrees C to 8 degrees C and longer than 6 hours at warmer than 8 degrees C before they are sterilized shall meet the sterility test (see Sterility Tests <71>) before they are dispensed or administered." Recommend removing the language, "with any ingredient that was at any time non-sterile, regardless of intervening sterilization of that ingredient." Rationale: All ingredients were non-sterile at one time, e.g. the ingredients in sterile products from pharmaceutical manufacturers were at one time non-sterile before being sterilized.
1735.1(v)	**Precision Pharmacy** Rachel Taggs	"Non-sterile to sterile batch"- Please see 1751.7(e) and 1751.8(c). These definitions appear to be contradictory.
1735.1(v)	**Eagle Analytical Services** William Zolner	A strict interpretation of this definition would eliminate the category of a sterile-to-sterile batch, as referred to in other sections of the regulations. At one time all materials or ingredients were non-sterile, and had to be processed to make them sterile. I believe the intent of the definition would be clearer if the following was added to the definition, Insert: "….units with any compounded preparation or ingredient that…"
1735.1(w)	**Pioneers Memorial** John Teague	parenteral as defined by "stedmans medical dictionary" refers to injection by subQ, IM or intramedullary. How is parenteral also inhalation and eye drops?
1735.1(w)	**Precision Pharmacy** Rachel Taggs	Why are ophthalmic preparations considered parenteral and not topical? USP definition: Parenteral drug products include both injections and implanted drug products that are injected through the skin or other external boundary tissue, or implanted within the body to allow the direct administration of the active drug substance(s) into blood vessels, organs, tissues, or lesions
1735.1(w)	**University Compounding Pharmacy** Joe Grasela	Please clarify where "irrigation preparations" would be categorized as. Will they be considered "parental" as well?

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1735.1(y) Removed Definition	**Barcon & Associates** Douglas Barcon, Pharm.D	This important paragraph was deleted from the proposed regulation and should be restored for patient safety and certification reasons. Cleanrooms employed in sterile compounding are usually dilution control (turbulent airflow) ISO class 7 buffer areas with ISO class 8 or better ante-area. The ISO class 5 clean-zone utilizes unidirectional (laminar) flow control instead of dilution control and should be measured in terms of velocity. The Controlled Environment Testing Association (CETA) specifies the airflow smoke pattern test in CAG-003-2006v11 Jan 2012, the CETA Certification Guide for Sterile Compounding Facilities. A visible source of smoke such as a glycol-based smoke generator or a smoke tube is used to observe air patterns within the unidirectional space. The smoke is toxic or irritating, but only a miniscule amount for a very limited duration is used, and it rapidly dissipates in the airflow and air changes within the ISO class 5 PEC and cleanroom, so it does not pose safety concerns. Smoke products have been used for years in the certification process and will continue to be used. Specific procedures are not detailed in any cleanroom testing standards. The intentions are clearly stated, however, in the FDA guidance document for industry “Sterile Drug Products Produced by Aseptic Processing – Current Good Manufacturing Practice”. “In situ air pattern analysis should be conducted at the critical area to demonstrate unidirectional airflow and sweeping action over and away from the product under dynamic conditions.” This is also addressed in USP 797. Without the smoke test, certifiers cannot confirm that the airflow in an ISO class 5 PEC is laminar (unidirectional) flow within the working area for certification when it is empty or when it is operating in dynamic conditions with vials, hanging bags, hanging bottles, TPN compounders, and employees hands and arms present in the working area. The smoke test can determine where the airflow is unidirectional and where it is turbulent and incapable of sweeping away particles. Suggested text restore in regulation 1735.1: “Smoke test” means an analysis of the airflow in the ISO Class 5 PEC and cleanroom using a smoke generating device.
1735.1(y)	**Mercy General Hospital** Jeffrey Nehira	Suggest adding an appendix of USP34-NG32, 37th Revision referencing “Potency” to the policy for easier referencing of USP version required in CA Pharmacy Law. This has changed since the last draft and should be reviewed through the BOP for adoption when changes are made.
1735.1(y)	**California Hospital Association** BJ Bartleson	Rewrite section (y) saying, “"*Potency" means active ingredient strength within +/- 10% of the labeled amount except when limited to sterile commercial products when the strength must be calculated as the result of a master formula* . Sterile commercial products are already at +/- 10% so unable to meet this requirement for compounded products

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1735.1(y)	**PharMEDium Services, LLC** Rich Kruzynski	On page 5 of 46, in Section 1735.1.Compounding Definitions, we propose modification of the definition of (y) "Potency", as follows: (y)"Potency" means active ingredient strength within+/- 10% (or the range specified in the most current version of USP ~~USP37 W32,37ltl Revision, Through 2Ad Supplement Effective December 1, 2014)~~ of the labeled amount, or +/-10% of the expected strength when following manufacturers' labeling/directions for diluting or reconstituting of FDA approved sterile components (e.g. drug and diluent).
1735.1(y)	**California Society of Health-System Pharmacists** Dawn Benton	Recommendation: Problem with serial dilutions when the original product is +/- 10%. Modification recommended as follows: 1735.1 (y) “Potency” means active ingredient strength within +/- 10% or the range calculated as part of the master formula (or the range specified in USP37-NF32, 37th Revision, Through 2nd Supplement Effective December 1, 2014) of the labeled amount.
1735.1(y)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: USP 797 only describes potency in terms of ensuring potency by monitoring controlled storage areas. In addition, considering the many drugs that could be compounded (biosimilars, immune mediators, blood derivatives, etc) it may be too arbitrary to put such a hard limit on this definition. Solution: Remove section that defines “potency” altogether.
1735.1(aa)	**Pioneers Memorial** John Teague	I’m confused on the “prescriber’s office” definition, I’m lost on the double underline section. How is this going to effect a facility with clinics that are under the same license as the hospital/pharmacy that are adjacent but not within the same building?
1735.1(aa)	**Precision Pharmacy** Rachel Taggs	Does this not include a mobile veterinarian who stocks office use medications on their truck to visit large horse farms/ranches to treat their patients. Would a truck be considered an “office”? Please note that veterinary hospitals are very different than human hospitals as they can serve as both an inpatient facility/hospital and as an outpatient facility/clinic.
1735.1(ab)	**Mercy General Hospital** Jeffrey Nehira	Under PEC I would remove the wording “…through the use of unidirectional HEPA filtered first air.” from the definition as it also is not in USP797. Although it is implied that through the PEC directional flow would be one way, most negative pressure glove boxes can be configured for both positive and negative pressure.
1735.1(ac)	**Mercy General Hospital** Jeffrey Nehira	In the definition of process validation, the second sentence needs more clarification, “If any aspect of the process is changed, the process would need to revalidated.” This is required by pharmaceutical manufacturing, and is not necessarily practical for hospital practice.

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1735.1(ae)	**Mercy General Hospital** Jeffrey Nehira	Listing "inactive ingredients" in this definition implies that all inactive ingredients should be present on the log of all compounded prescriptions as a quality measure, including those used in hospital practice. Clarification is needed regarding the requirement to listing inactive ingredients on a hospital compounding log or creating exemptions for acute care settings. Inactive ingredients can be traced back through lot numbers and NDCs of primary medications.
1735.1(af)	**Pioneers Memorial** John Teague	my facility is limited on space and currently has plans to locate the CACI for chemo pre across the hall from the main pharmacy. Issue is that the adjacent department is the cafeteria, but the plans are moving through the OSHPD approval with 100% venting etc, how can a CACI not be placed in any area especially if the manufacturer has tested it? Biggest issue here is compliance with the regulations that are also impacted by other state agencies that already oversee these areas i.e. OSHPD. OSHPD is a California state agency that has already addressed these issues and makes it difficult to comply as it appears that both state agencies are working independently
1735.1(af)	**Cedars-Sinai** Katherine Palmer Rita Shane	~~The segregated sterile compounding area shall be restricted to preparing non- hazardous sterile-to-sterile compounded preparations.~~ It is unclear as to why hazardous sterile-to-sterile medications cannot be compounded in a segregated room as long as the dating requirements are met as described in 1751.8(e) p. 40.
1735.1(af)	**Mercy General Hospital** Jeffrey Nehira	The third and fourth sentences in the definition of Segregated Compounding Area is not in the definition within USP797 and would recommend removal. This also brings into questions definitions of “high traffic flow”, what is considered “adjacent to a construction site”, etc. For older facilities/hospitals that are constantly renovating, the definition of what is considered a construction site or area can be anywhere in the facility.
1735.1(af)	**California Society of Health-System Pharmacists** Dawn Benton	If a pharmacy is engaged in more than low volume hazardous drug compounding, but the PEC is not currently located in a negative pressure room, what is the expectation from the Board of Pharmacy re transition to negative pressure space? Is there a planning and implementation period? Can the institution wait for the USP800 release to develop a comprehensive remodel? Can a CACI with two levels of protection be used as an intermediate solution?

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1735.1(af)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Recommend allowing compounding of hazardous drugs in a segregated compounding area within a CACI by removing the language “non-hazardous” from “The segregated sterile compounding area shall be restricted to preparing non-hazardous sterile to sterile compounded preparations.” Rationale: USP 797 definition of a Segregated compounding area is “a designated space, either a demarcated area or room, that is restricted to preparing low-risk level CSPs with 12 hour or less BUD”. USP 797 section Placement of Primary Engineering Controls allows placement of a CACI (used for hazardous drug compounding) in less clean than ISO Class 7 areas if the following conditions are met: -The isolator shall provide isolation from the room and maintain ISO Class 5 during the dynamic operating conditions, including transferring ingredients, components, and devices into and out of the isolator and during preparation of CSPs -Particle counts sampled approximately 6 to 12 inches upstream of the critical exposure site shall maintain ISO Class 5 levels during compounding operations -Not more than 3520 particles per m3 shall be counted during material transfer, with the particle count probe located as near to the transfer door as possible without obstructing the transfer.
1735.1(af)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: Many hospitals have established pharmacy satellites nearby patient care areas to serve our most vulnerable patients (e.g. Intensive Care Units). The central pharmacy is too far from these patient care areas and the pharmacy satellites provide a venue to provide patient care that is closer to the patients. These pharmacy satellites are one room that provides a place for the pharmacy to perform order verification, drug storage, and drug preparation. Many of the pharmacy satellites have very limited room, thus the pharmacy will place compounding aseptic containment isolators (CACIs) which are enclosed to the surrounding environment and should have evidence from the manufacturer that they meet USP chapter 797 and Controlled Environment Testing Association (CETA) requirements. If one were to believe that this is an unverified study then one would have to question most of the conclusions derived from USP 797 as many of the conclusions taken from there are not based on “randomized controlled trials”. We believe that we can remove the 3 foot no sink/drain requirement when CACIs are used to support pharmacy satellites. The alternative would be to close these pharmacy satellites that do not have the room to abide by the 3 foot no sink/drain rule which is not consistent with a patient centered care model. Solution: Make an exception that if the ISO Class 5 PEC is a CACI, that the three foot sink/drain rule does not apply while maintaining that sinks and drains should not be placed in a buffer area or in ISO class 7 or better.
1735.1(ag)	**Precision Pharmacy** Rachel Taggs	“Strength” - with the insertion of the word “dosage” unit is what causes the confusion with sections: 1735.1(n) and 1735.1 (v). The amount active ingredient per unit is a more clear definition, where the unit is “mL, mg, gm, capsule, etc”
1735.2(b)	**Precision Pharmacy** Rachel Taggs	1735.2 (b) Please include language for the allowance of preparation of limited quantities of compounded preparations in advance of prescriber office use orders where there is a documented history of orders for that prescriber population. This is especially important in veterinary medicine where they frequently require the use of both sterile and non- sterile medications for veterinarian administration.

Code Section	Commenter	Comment
1735.2(c) - 1735.2(6)	**Westcliff Compounding** Mike Pavlovich	In light of the changes in effect since the FDA's declaration that "office use compounding" is no longer permitted by 503A establishments, and should be restricted to sterile compounding only by 503B establishments, I wounder if Section 1735.2 (c) through 1735.2 (6) are even feasible as stated any longer. Is the Board prepared to allow the continuation of "office use compounding" in what appears to be direct conflict with current FDA policy? There are clearly occasions, in my opinion, where it is appropriate, but limitations are sorely needed to prevent or curb potential abuses. I receive almost daily requests from prescribers to prepare a variety of non-sterile preparations and have to refer them to the FDA declaration from September. Has FDA revised their position recently? I have not seen anything in relation to this policy.
1753.2(c)(1) Incorrect Sec. Should be 1735.2(c)(1)	**Mercy General Hospital** Jeffrey Nehira	The new requirement to have the prescriber list the number of patients seen in the office and have pharmacies calculate a 72 hour supply is impractical and would require a scope of record keeping difficult to enforce. The prescriber can list any number of patients on the prescription, and the pharmacy would have to dispense any amount required for the 72 hour supply. The previous definition that the prescriber could only provide up to a 72 hour supply for the patient is more practical.
1735.2(c)(1)	**Precision Pharmacy** Rachel Taggs	How do we determine a fair market value of a compounded preparation? There's no way to determine this with specialty veterinary medications when there is no commercial alternative.
1735.2(c)(1)	**Precision Pharmacy** Rachel Taggs	Suggestion to leave in the crossed out section because it leaves it unclear to whom a 72-hour supply may be furnished to. The requirement of "listing the number of patients seen or to be seen in the prescriber's office for whom the drug is needed or anticipated and the quantity for each patient that is sufficient for either office administration or furnishing of a 72 hour supply" is going to be extremely difficult for veterinarians. They see patients that can often range from a small 5 lb cat to a large 1200 lb horse and the dosages may vary greatly making it hard to predict. Many of the patients veterinarians see are brought in by their owners when the animal is sick or there is an emergency and the veterinarian needs to have the medication on hand for these types of situations

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1735.2(c)(1)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	This proposed regulatory language is vague and does not reflect either California statutory authority nor federal case law. The term “fair market value” cannot practically apply to pharmacy-compounded items because there are no published prices that compounding pharmacies can use to determine that fair market value, unlike resources that are available for products approved for distribution in interstate commerce by the FDA. Compounding pharmacies are prohibited by anti-trust law from contacting other compounding pharmacies to discuss what are the established prices. Further, there is no reference material available to even determine which competing pharmacies are compounding and distributing the exact same compounded products. Each compounding pharmacy has to determine its own pricing based on its costs, risk calculations, and marketing strategy. Generally speaking the costs per unit compounded by a pharmacy will be substantially higher than the market value of FDA approved similar products because of a lack of “economy of scale” vs manufacturing facilities. Further, Calif. Business and Professions Code Section 4380 establishes in California statutory law recognition of two federal court cases that allow non-profit institutions to acquire products at prices generally unavailable to for-profit organizations and use of those products for the treatment of specified patients related to the not-for-profit institutions, e.g. certain hospitals and health plans. Such products are often supplied to physicians in medical office environments at no charge for treatment of such patients. This includes pharmacy-compounded products supplied to prescribers for prescriber office use under Business and Professions Code Section 4052(a)(1).
1735.2(c)(1)	**California Veterinary Medical Association** Valerie Fenstermaker	For the addition of "fair estimate language": Veterinary practices treat multiple species of animals on a prescheduled, walk-in, and emergency basis- thus making day to day operation unpredictable. Patients differ significantly in weight, health status, anatomy and physiology. There is a wide variation between species in effective dosage ranges and toxicity levels for each drug used. These factors make it difficult for veterinary practices to foresee the exact number of patients and quantity of compounded drugs that will be used. Recommended Language: (1) is ordered by the prescriber or the prescriber's agent and paid for by the prescriber at a price that fairly reflects the fair market value of each drug preparation, using a purchase order or other documentation received by the pharmacy prior to furnishing that lists the number of patients seen or a fair estimate of the number of patients to be seen in the prescriber's office for whom the drug is needed or anticipate, and a fair estimate of the quantity for each patient that is sufficient for either office administration or application to patients in the prescriber's office, or for distribution of not more than or furnishing of a 72-hour supply to the prescriber's patients, as estimated by the prescriber; and

Code Section	Commenter	Comment
1735.2(c)(1)	**Hartley Medical** William Stuart	1. Will pharmacies be responsible for relaying this change to all prescribers? Doing such will be an administrative burden for both prescriber and pharmacy staff. 2. Using the word “list” implies a prescriber include a list with patient names. Privacy and security of patient health information, the transmission of such information, and recordkeeping of said document would need to be addressed in this subsection. 3. A prescriber cannot estimate patient non-compliance in the event patients do not show up for their appointments or reschedule. Recommend: …using a purchase order or other documentation received by the pharmacy prior to furnishing that ~~lists~~ quantifies the number of patients seen or to be seen in the prescriber’s office for whom the drug is needed or anticipated, and ~~the~~ an estimated quantity ~~for each patient~~ that is sufficient for either office administration or furnishing of a 72-hour supply reasonable for the amount being ordered.
1753.2(c)(2) Incorrect Sec. Should be 1735.2(c)(2)	**Mercy General Hospital** Jeffrey Nehira	To deliver to the prescriber’s office puts excessive burden on the distributing pharmacy and is very inefficient operationally. Prescriber's often order medications for office use, and pick them up from the pharmacy.
1735.2(c)(2)	**Precision Pharmacy** Rachel Taggs	Large animal veterinarians are often mobile and go out to barns and stables to see patients; practices are often ran solely by the prescriber without an agent and they are not always available to sign for a delivery. Delivery confirmation is available via tracking reference numbers
1735.2(c)(3)	**Precision Pharmacy** Rachel Taggs	See comments above for1735.2 (c) (1) same concept

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1735.2(c)(3)	**California Veterinary Medical Association** Valerie Fenstermaker	For the 120-hour dispensation amendment: - Allowing a 120-hour dispensation allotment will help to ensure that sick pets are receiving medications such as antibiotics and pain medication without interruption during the time which they are most critically needed. The largest and more commonly used veterinary compounders in the country are located outside the Pacific Standard time zone. This can create added burden when attempting to obtain compounded medications for sick pets since up to three hours can be lost when working with these pharmacies- sometimes resulting in a business day, or even a weekend being lost before a prescription can be filled and shipped. - The United States Postal Service as well as other private carriers cannot always guarantee delivery within three days. - Because many of the medications that veterinarians request are not common, compounding pharmacies are not always able to formulate and ship them in time to meet the 72-hour time frame. - Many compounding pharmacies are unable or unwilling to fill veterinary prescriptions. Reasons include: The pharmacy may not stock the ingredients to fill the prescription, The pharmacy may have a policy of not filling prescriptions for pets, Compounding veterinary formulations could be cost prohibitive. - When a medication is in short supply, it can be much more difficult to obtain it through a compounding pharmacy, since in many instances pharmacies fill human prescriptions as a matter of priority over pets. Having the ability to dispense a 120-hour supply from an in-house stock will provide more flexibility and much needed time in getting a prescription filled at a compounding pharmacy. This will ultimately minimize animal suffering by enabling the veterinarian to provide needed medication in the time most critical to the sick animal. Recommended Language: (3) is sufficient for administration or application to patients solely in the prescriber's office, or for furnishing of not more than a 72-hour supply for human medical practices, or a 120-hour supply for veterinary medical practices, solely to the prescriber's own patients seen as part of regular treatment in the prescriber's office, as fairly estimated by the prescriber and documented on the purchase order or other documentation submitted to the pharmacy prior to furnishing
1735.2(d)	**Providence Heath & Services Southern California Region**	No pharmacy or pharmacist shall compound a **sterile** drug preparation that:

Code Section	Commenter	Comment
1753.2(d)(2) Incorrect Sec. Should be 1735.2(d)(2)	**Mercy General Hospital** Jeffrey Nehira	An exemption should be made for sanctioned drug studies. Although medications can be removed from the market for one indication, they should be able to get re-introduced and compounded if they are a study drug (this commonly occurs for medications that have a NDA for a separate indication.)
1735.2(d)(2)	**Precision Pharmacy** Rachel Taggs	Please add clarification that this would apply to human drugs only. Example Cisapride (Propulsid) was withdrawn from market in 2000 due to fatal cardiac arrhythmias however it is commonly used for chronic constipations in cats
1735.2(d)(3)	**Precision Pharmacy** Rachel Taggs	Veterinary commercial products are rarely updated on the FDA Veterinary Shortage List. Human drug shortage lists for the FDA and ASHP do not contain veterinary products. The ability to have documentation from veterinary drug wholesalers when a commercial veterinary product goes on backorder provides us with more up to date and accurate information to meet veterinary patient needs
1735.2(d)(3)	**Kaweah Delta Medical Center** Rheta Sandoval, Pharm.D.	Many drug shortages that impact facilities do not appear on the “ASHP or FDA list of drugs that are in short supply”. The medication in “short supply” may be a temporary supply interruption that impacts a region or a single facility in which case it may not appear or there may be a considerable delay in appearing on the ASHP or FDA list of drugs that are in short supply. The current language does not accommodate these scenarios that are often faced in the industry and inserts unnecessary and potentially unsafe barriers to patients receiving a critically needed medication. If a medication has been compounded after determining the preparation meets the requirements of this section, please allow its’ dispensing up until the beyond use date. It would be a waste of precious drug resources to not permit use of a compounded preparation that is still suitable for use but is no longer on the ASHP or FDA list.

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1735.2(d)(3)	**Kaweah Delta Medical Center** Rheta Sandoval, Pharm.D.	Concerned about the language “and the compounding of that drug preparation is justified by a specific, documented medical need made known to the pharmacist prior to compounding”. It could be interpreted that prior to compounding each dosing unit, a pharmacist must assess for a medical need and then document that need prior to compounding. If this interpretation is the intent of the modified text, this would be burdensome to accomplish, it would introduce a layer of complexity to drug shortage management that could be detrimental to patient care and would require significant communication between outsourced facilities and their customers (namely pharmacies) to achieve. One could argue that a medical need is established by the prescriber prior to writing the chart order or prescription. In the hospital pharmacy industry, it is common to have a buyer managing drug inventory. In the event a facility is facing a supply interruption, the FDA and ASHP drug shortage lists are reviewed and alternate means to obtain the needed medication are explored whether it be via the wholesaler or an alternate division of the same wholesaler or through a direct purchase from the manufacturer. If after these avenues are exhausted, a pharmacist then makes a determination that it is necessary (medical need) to compound a copy or essentially a copy of a commercially available product OR seek the same from an outsourced facility and proceeds with the purchase from an outsourced pharmacy or begins to compound the medication in-house. Sometimes, the decision to proceed is based on uncertain need, as a contingency to assure patient care is not jeopardized. It should be noted, that this is a generalized approach to managing through drug shortages and the specific steps taken are dependent on many factors such as drug patterns of use and estimations of days supply on hand. Please consider making it permissible to allow for the Pharmacist(s) involved in managing inventory to make decisions they deem necessary and document “patient need” in their drug shortage plan as a whole rather than per patient, per dosage unit compounded. Please consider revising to: “is a copy or essentially a copy of one or more commercially available drug products, **unless at the time of compounding** that drug product appears on an ASHP (American Society of Health-System Pharmacists) or FDA list of drugs that are in short supply **or there is a supply interruption that does not appear on these lists** ~~at the time of compounding and at the time of dispense~~, and the compounding of that drug preparation is justified by a specific, documented medical need made known to the pharmacist prior to compounding.

Code Section	Commenter	Comment
1735.2(d)(3)	**Providence Heath & Services Southern California Region**	(3) is a copy or essentially a copy of one or more commercially available **compendial** drug products… Add to Section 1735.1 definition: Compendial drugs are drug products or preparations for which there is a monograph provided in an official compendia (e.g. United States Pharmacopeia, National Formulary, or Homeopathic Pharmacopeia) recognized by the Food, Drug, and Cosmetic Act. The compendium sets forth standards for the strength, quality and purity of the drug product. -OR- Add: (4) Compounding (reconstitution and/or dilution) of FDA approved drug products is excluded from this restriction. If the intent of the board was to prevent what would essentially be the manufacturing of copies of compendial drug products by pharmacies, the language needs to be modified to clearly indicate this. Dilution/reconstitution and compounding of drug products using FDA-approved drug products should be exempted. Providence recommends changing the language to allow compounding (reconstitution and/or dilution) using FDA-approved drug products. The proposed language seen in the center column can be interpreted to prohibit dilution of FDA-approved drug products per FDA instructions, if there is a pre- diluted (premix) drug product commercially available. As defined in 1735.1(l) “copy or essentially a copy” of a commercially-available drug product would include all diluted intravenous infusion bags, including IV piggy backs or IVPBs that are available as premix bags from the manufacturer. Some brand name manufacturers have FDA-approved “premixed” IV bags that are ready-to-administer and are virtually the same preparation as other FDA-approved drug vials that are diluted prior to administration per the FDA-approved package insert instructions. Premix IV bags would fall into the definition since they are commercially-available drug products.

Code Section	Commenter	Comment
1735.2(d)(3) (Continued)	**Providence Heath & Services Southern California Region**	For example: Vancomycin is available as a frozen premix IVPB bag in different strengths that are the most commonly prescribed (e.g., 1 gram). The frozen premix bag is thawed and administered to the patient without further dilution. Vancomycin is more commonly available as a sterile powder vial that requires further dilution (per FDA-approved package insert instructions and labeling) into an IV solution bag prior to administration. Vancomycin premix IVPB is 1 gram of vancomycin in D5W 200ml. Pharmacies can typically prepare that same IVPB bag of 1 gram of vancomycin in D5W 200ml using a vancomycin sterile powder vial, reconstituting it as directed with sterile water and further diluting the 1 gram amount into an IVPB bag of D5W solution. The resulting preparations are the same: same active and inactive drug and diluent, same dose, same volume. The cost of utilizing the sterile powder vial of vancomycin and the plain D5W IV solution bag is less expensive than purchasing the vancomycin bag that is already diluted and ready-to-administer. The current wording of 1735.2(d)(3) prohibits pharmacies from diluting their own vancomycin 1 gram as in the example above because it is “essentially a copy” of a commercially-available drug product. The implications of this restriction would be far-reaching: - Costs to pharmacies and costs to treat patients would be exponentially more expensive if pharmacies cannot compound their own sterile IVPBs even when a commercial premix product is available. - Manufacturers who produce premixed products would corner the market and profit from this regulation. Generic drug manufacturers that produce FDA approved drug vials and solutions to be used for sterile compounding will suffer. - Drug shortages will worsen since premix sterile dilution products are the only ones that could be used in the state. It will drive the demand for these premix IVPB products and the lone manufacturers would not be able to meet the needs of pharmacies. - In the event of a drug recall of a premix commercially-available product, pharmacies may not be able to perform compounding unless the drug appears on the ASHP or FDA drug shortage list. If the rest of the country is not restricting pharmacies from compounding copies or essential copies of commercially-available drug products, no shortage will be listed.

Code Section	Commenter	Comment
1735.2(d)(3) (Continued)	**Providence Heath & Services Southern California Region**	Even TPN (total parenteral nutrition) is available commercially as premixed bags. TPN contents are usually customized to meet the nutrition, caloric, and electrolyte needs for the patient. Some of the TPN formulas are available as premixed bags from the manufacturers. The language in this section would prohibit the pharmacy from preparing a TPN formula that matches those available as TPN products. It would not be feasible for pharmacies to stock every commercially available TPN bag in order to provide the TPN needs for every patient. Being able to compound the TPN using sterile products is a necessity. We agree that preparation of sterile drug products that are copies or essentially copies of commercially-available drug products should be prohibited when those processes involve utilizing non-sterile ingredients to prepare sterile drug products unless there is a documented current drug shortage and appropriate safety measures and procedures are followed. For example, preparation of calcium chloride sterile solution for injection utilizing non-sterile calcium powder. Non-sterile compounding of commercially- available drugs should be permitted for non-parenteral administration. For example, caffeine citrate oral solution is commercially available in a ready-to- administer solution but is also safely compounded utilizing caffeine powder, citric acid powder, and water to prepare essentially the same drug product with the strength/concentration and formulation. Stability studies have been done on the extemporaneous compounded formulation from these powders and have been shown to be safe and effective for treating patients.
1735.2(d)(3)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: Many medications that are in short supply in “real time” may not be on the ASHP or FDA drug shortage list in a timely manner (e.g. most recent example IV Protonix January 2015). ASHP and FDA recognize that this may happen as they have to rely on clear communications to them for their source of information. Solution: Add “Manufacturer, Wholesaler, and/or Distributor acknowledge and provide documentation that the drug is in short supply.”
1753.2(d)(3) Incorrect Sec. Should be 1735.2(d)(3)	**Mercy General Hospital** Jeffrey Nehira	Preparing CSPs in a hospital setting to be medically necessary is sometimes required even though products are commercially available, especially in DSH hospitals or in rural areas where medications may be immediately necessary and not available for delivery for an extended period of time. I believe an exemption should be written for urgent/emergent care or when medically necessary. With the amount of shortages that are occuring in todays environment, maintaining documentation of drug shortages that are in the high hundreds to thousands provides an undo burden on pharmacies; particularly in acute care settings.
1735.2(e)	**Valley Children's Hospital** Richard Sakai	Add A drug preparation ……the following elements *unless it is deemed that a delay would result in patient harm whereas the written master formula will be prepared within 24 hours of dispensing* . Creating a new written master formula prior to compounding may result in delay in patient care. The development of quality reviews at each step in preparation of the drug will delay the process as being prescribed to be completed prior to compounding.

Code Section	Commenter	Comment
1735.2(e)(4)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: The language may be too broad. We understand it would be hard to place exactly what is required considering all of the entities that will be using these regulations, but perhaps we can narrow the language by inserting phrases such as “essential compounding steps”. This will help facilitate pharmacies to receive approval during the policy approving process who are based in institutions with multidisciplinary committees by leaving out unwanted minutia of the compounding process in policies and procedures. Solution: Reword section to state “Specific and essential compounding steps used to prepare the drug”
1753.2(e)(5) Incorrect Sec. Should be 1735.2(e)(5)	**Mercy General Hospital** Jeffrey Nehira	Clarification or an example regarding "specific compounding steps" is necessary to prevent confusion on what information is necessary.
1735.2(e)(6)	**Valley Children's Hospital** Richard Sakai	Quality reviews *shall be developed and monitored as appropriate.* *The creation of a quality review of the process is important but a quality review for every single step of the process would be excessive and should concentrate on the appropriate parts of the compounding process.*
1735.2(g)	**Kaweah Delta Medical Center** Rheta Sandoval, Pharm.D.	Concerned about the language “until the beyond use date indicated on the label, so long as label instructions for storage and handling are followed after the preparation is dispensed.” Label instructions related to storage and handling are usually limited to storage temperature and protect from light and/or humidity. Typically, label instructions would not address security, aseptic technique when accessing the vial, etc. To require that a pharmacist be responsible for the integrity, potency, quality, and labeled strength until the beyond use date is a considerable responsibility given the factors that influence this after dispensing are largely outside of the control of the Pharmacist dispensing the compounded drug preparation. It does not seem reasonable to hold the Pharmacist responsible for a responsibility that it shared between the Pharmacist and patient, a Pharmacist and Prescriber (in situations where a preparation is furnished to a prescriber office), a Manufacturer and Pharmacist.
1735.2(i)	**Pioneers Memorial** John Teague	this section doesn’t make sense, you should only be able to utilize a resource to determine the BUD as long as you are using identical components and packaging. If you reference the authority on sterile compounding Trissels you will note a difference in product integrity based on components and packaging. LR is not the same as NS and Baxter and BBRAUN IV solutions are also different.
1735.2(i)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Recommendation: Eliminate the word “used” to be in concordance with the definition of BUD in 1735.1

Code Section	Commenter	Comment
1735.3(a)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Recommend changing 1735.3 (a) (1) to read: “A reference to the applicable version of the master formula.” Rationale: for consistency, master formula documentation is often maintained centrally in electronic records or locally in bound volumes. Requiring duplication on the compounding record is unnecessary. A master formula may be changed periodically and the compounding record should reference the version used for that particular preparation Recommend removing the documentation for storage of the drug preparation from 1735.3(a)(10) and adding this to section 1735.2(e) to be included as a requirement for the master formula record for the drug preparation. Rationale: Storage requirements for the compounded drug preparation should be consistent each time it is compounded or batch prepared and included in the master formula
1735.3(a)(8)	**Harbor Compounding Pharmacy** Mai Tran Sam Kitahara	Please eliminate the time format from the record keeping or keep it as an option. Please define what “time” means. Does time mean the time the formula was printed or the time the compounding started or the time the compounding finished? The beyond use date or beyond use date and time of the final compounded drug preparation, expressed in the compounding record in a standard date and/or time format (MM/DD/YYYY and/or HH:MM).
1735.3(a)(8)	**California Pharmacist Association** Brian Warren	(8) The expiration beyond use date or beyond use date and time of the final compounded drug product preparation, expressed in the compounding record in a standard date format (MM/DD) or date and time format (MM/DD/YYYY and HH:MM). Section 1735.3(a)(8) requires pharmacies to record the “beyond use date or beyond use date and time” (emphasis added). However, the modified text only proposes a standard format for recording beyond use date and time. The modified text does not propose a standard format for beyond use date (without time). We recommend adding a format for recording the beyond use date (without time), as is allowed in the regulation.
1735.3(a)(8)	**Kaweah Delta Medical Center** Rheta Sandoval, Pharm.D.	Please delete “expressed in the compounding record in standard date and time format (MM/DD/YYYY and HH:MM)” too rigid of a requirement may be difficult to hardwire compliance, unclear patient benefit.
1735.3(a)(8)	**Precision Pharmacy** Rachel Taggs	Please clarify that time format for beyond use dates should only apply to immediate use preparations with less than 24 hour beyond use date

Code Section	Commenter	Comment
1735.3(c)	**Precision Pharmacy** Rachel Taggs	"Active ingredients shall be obtained from a supplier registered with the FDA." When an active ingredient for a veterinary drug is not available from an FDA registered supplier, can the ingredient be purchased and used as long as a Certificate of Analysis is obtained from a reliable supplier? Recommend changing language to coincide with USP to change "shall" be obtained from supplier registered with FDA to "should" be obtained when available from supplier registered with FDA. USP 795 - Compounders shall first attempt to use components manufactured in an FDA- registered facility. When components cannot be obtained from an FDA-registered facility, compounders shall use their professional judgment in selecting an acceptable and reliable source and shall establish purity and safety by reasonable means, which should include Certificate of Analysis, manufacturer reputation, and reliability of source.
1735.4(b)	**Community Regional Medical Center** Bruce Lepley	**Reason for Concern:** In most hospitals, patients can be under the direct care of the hospital and physically in the hospital and registered without technically having an "inpatient account". As an example, a patient can be under the direct care of the hospital, physically in the hospital, registered, and be under the care of "inpatient health care professionals" but be in a financial account status of "observation" which is a Medicare approved account status. If we can broaden this language it will still capture the patient population that was intended in this section without having to consider what type of financial account/status this patient will have while under the direct care of the inpatient hospital. Solution: Reword the section to state : 1735.4 (b) "Exempt from the requirements of this paragraph are those sterile drug preparations compounded within a health-care facility solely for administration, by a licensed health care professional, to a patient who is physically under the direct care of the facility."
1735.4(b)	**Cedars-Sinai** Katherine Palmer Rita Shane	Exempt from the requirements of this paragraph are those sterile drug preparations compounded within a health care facility solely for administration by a licensed health care professional, to ~~an inpatient~~ a patient in the facility.
1735.4(c)	**Mercy General Hospital** Jeffrey Nehira	With regard to drug labeling I believe this regulation requiring both the names of the compounding pharmacy and dispensing pharmacy, if different, should also state, "if not apparent from the container". Products may come from multiple sources and this requirement currently states that the pharmacy label should have both names. This is impracticle if the original pharmacy label is apparent from the prescription and has the information required. (ex. TPN formulations)
1735.5(c)(2)	**Pacific Compounding Pharmacy** Marie Cottman	**Comments:** I AGREE that evidence MUST be kept on record, but totally disagree with the need for it to be included within the policy and procedure manual! This training and education documentation will clutter the P&P and should not be kept where other peer employees can see employee performance documentation. Recommendation: Move this statement to section (d) and reword: (d) The pharmacy shall maintain written evidence that staff have been educated and trained on all policies and procedures.

Code Section	Commenter	Comment
1735.5(c)(3)	**Mercy General Hospital** Jeffrey Nehira	This statement conflicts with 1735.3(6). Recommend exempting compounds already dispensed and administered for one time administration.
1735.5(c)(5)	**Mercy General Hospital** Jeffrey Nehira	Reference to "disinfecting the facility (physical plant) used for compounding" needs clarification. Regulations already exist for the requirements of cleaning walls, ceilings, etc. The reference to "the facility (physical plant)" is not defined in the definitions at the beginning of the document.
1735.5(c)(8) and (9)	**Mercy General Hospital** Jeffrey Nehira	Recommend removal of the requirement for annual review. Although this is in current policy, this differs from other regulatory body requirements for hospitals. Request review, "at least every 3 years" or to similar verbiage in Title 22. Reference to "signed and dated by the pharmacist-in-charge" should be updated to include electronic signatures.
1735.5(c)(10)	**Mercy General Hospital** Jeffrey Nehira	Need further clarification regarding room temperature storage. Currently regulations state that medications are stored at controlled room temperature but there is no requirement for daily monitoring. Request an extended implementation date if this is now required for hospital settings.
1735.5(c)(11)	**Mercy General Hospital** Jeffrey Nehira	Suggest and exemption for health care settings with a facility services policy regarding appropriate function of refrigeration devices.
1735.6(d)	**Pioneers Memorial** John Teague	it's already mentioned that the two areas must be physically separated so I'm not sure how relevant this is. It would be more appropriate to require cleaning but also every 6 month surface sample testing to look for the presence of hazardous trace drugs contaminating the area. Currently we test for the top 5 chemo drugs to ensure the hazardous area is not contaminated.

Code Section	Commenter	Comment
1735.8(c)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Recommendation: Add language between the first and second sentences of 1735.8 (c) to clarify the exact requirements related to the quality assurance plan: "The criteria by which preparations would be tested for potency, quantitative analysis, and labeled strength analysis shall be described in the quality assurance plan. Rationale: This language could be interpreted to require that quantitative and qualitative analysis be performed on all compounded products regardless of cost, availability of the actual assay, or scientific validity. It has been our experience that some Board of Pharmacy inspectors have interpreted this language to require end product potency testing during of all pharmacy-compounded products. KP and many pharmacy professionals disagree with those requirements as they are inconsistent with the intent and provisions of the regulation 1735, et. seq. Pharmacies are compliant with 1735.8(c) if they have a PLAN that includes the elements mentioned above. Quantitative and qualitative laboratory type testing is not required unless specified for each product in our policies and procedures generally or by category - or in the Master Formula for a particular product. Test records of tests only have to be retained if such test was done either as a matter of policy or pursuant to an investigation after the raising of a quality concern for particular compounded preparation or a batch of a compounded preparation. Please see the detailed testimony from KP regarding this issue which was presented to the BOP Enforcement and Compounding Committee on September 16, 2014.
1735.8(e)	**Mercy General Hospital** Jeffrey Nehira	Suggest and exemption for health care settings with a facility services policy regarding appropriate function of refrigeration devices.
1751(b)	**Mercy General Hospital** Jeffrey Nehira	This requirement for venting may provide a challenge for DSH and rural hosptials. Request exemption for these settings. Referencing this code of regulations as an appendix in the CA law book would be helpful as the referenced chapter may change.
1751(b)	**Pacific Compounding Pharmacy** Marie Cottman	Comments: Please re-review Section 505.12 of Title 24, Part 4, Chapter 5 of the California Code of Regulations, as it is NOT current! It has been renumbered to 505.5.1 in the 2013 edition of the Mechanical Code. Reference: 2008 version http://www.iapmo.org/Code%20Errata/2007%20California%20Mechanical%20Code%20Errata/2007-CMC-Errata%20010208.pdf 2013 version: http://www.iapmo.org/2013%20California%20Mechanical%20Code/Chapter%2005.pdf
1751(b)(1)	**Pioneers Memorial** John Teague	remove "for" from the last sentence, "retained in the pharmacy".

Code Section	Commenter	Comment
1751(b)(1)	**Kaweah Delta Medical Center** Rheta Sandoval, Pharm.D.	For clarity, delete the word “for”
1751(b)(1)	**Valley Children's Hospital** Richard Sakai	Each ISO environment shall be certified at least every six months by a qualified technician for areas that are involved in compounding non-sterile to sterile products and annually for areas that are involved in compounding low risk products. Certification records must be retained for three years in the pharmacy. 1. USP797 recommends annual certification for areas involved in low and medium risk versus semi-annual for high risk compounding. 2. Three years is the usual time for maintaining pharmacy records.
1751(b)(3)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: Many hospitals have established pharmacy satellites nearby patient care areas to serve our most vulnerable patients (e.g. Intensive Care Units). The central pharmacy is too far from these patient care areas and the pharmacy satellites provide a venue to provide patient care that is closer to the patients. These pharmacy satellites are one room that provides a place for the pharmacy to perform order verification, drug storage, and drug preparation. Many of the pharmacy satellites have very limited room, thus the pharmacy will place compounding aseptic containment isolators (CACIs) which are enclosed to the surrounding environment and should have evidence from the manufacturer that they meet USP chapter 797 and Controlled Environment Testing Association (CETA) requirements. If one were to believe that this is an unverified study then one would have to question most of the conclusions derived from USP 797 as many of the conclusions taken from there are not based on “randomized controlled trials”. We believe that we can remove the 3 foot no sink/drain requirement when CACIs are used to support pharmacy satellites. The alternative would be to close these pharmacy satellites that do not have the room to abide by the 3 foot no sink/drain rule which is not consistent with a patient centered care model. Solution: Make an exception that if the ISO Class 5 PEC is a CACI, that the three foot sink/drain rule does not apply while maintaining that sinks and drains should not be placed in a buffer area or in ISO class 7 or better.

Code Section	Commenter	Comment
1751.1(a)	**Kaweah Delta Medical Center** Rheta Sandoval, Pharm.D.	The term “within” that applies to records described in Sections (a)(1-10) of this subdivision is restrictive and may not be possible for some pharmacies due to space limitations. Some of these records are considered confidential personnel records that may not be appropriately stored within the pharmacy but best stored in the Pharmacies administrative offices, which may be on the same premises of the pharmacy but not in the same physical space as the pharmacy. If we have a waiver to hold records offsite, would it be valid for these records? Please consider deleting the language “must be made and kept by within the pharmacy” in its entirety.
1751.1(a)(5)	**Mercy General Hospital** Jeffrey Nehira	See comment for: 1735.5 (c)10 above.
1751.1(a)(7)	**Mercy General Hospital** Jeffrey Nehira	Currently the technology does not exist for mobile isolation chambers and barrior isolators to measure the pressure differential of the ISO-7 area of the divices. Only the pressure associated with the ISO-5 compounding area. Clarification needs to be made regarding this requirement. For areas/rooms utilizing laminar flow hoods, it is impracitcal for daily monitoring of the pressure differential between areas. There has been no studies done indicating that a drop in pressure leads to an increase in contaminated preparations. Recommend removing the requirement for MICs/Barrior Isolators and changing the requirement for testing to every 6 months for room compliance.
1751.1(a)(10)	**Valley Children's Hospital** Richard Sakai	Preparation records including……and records of end-product evaluation results. "end-product valuation" should be defined in 1735.1 Compounding defintions section to avoid confusion. This could be defined as a visual review of the product ensuring that it is void of particulates versus complete culturing and testing for potency.
1751.1(b)	**Kaweah Delta Medical Center** Rheta Sandoval, Pharm.D.	The date on which the preparation was provided to a prescriber, the name, address, and license number of the prescriber is only applicable when furnishing to a prescriber. A hospital may compound for future use pursuant to 1753.3 and dispense to a patient. Consider inserting the words “and when applicable” immediately proceeding the words “the date”
1751.2(a)	**Cedars-Sinai** Katherine Palmer Rita Shane	The telephone number is not required on the label for sterile drug preparations dispensed to ~~in~~patients ~~by a hospital pharmacy~~ receiving an infusion in the hospital. Not all patients treated in hospitals are inpatients, for example, 23-hour observation patients.

Code Section	Commenter	Comment
1751.2(a)	**Providence Heath & Services Southern California Region**	(a) The telephone number is not required on the label for sterile drug preparations dispensed to inpatients by a hospital pharmacy. Providence recommends deleting the first sentence to clarify that the telephone number is not required for hospital pharmacy preparations for inpatients.
1751.2(a)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: In most hospitals, patients can be under the direct care of the hospital and physically in the hospital and registered without technically having an "inpatient account". As an example, a patient can be under the direct care of the hospital, physically in the hospital, registered, and be under the care of "inpatient health care professionals" but be in a financial account status of "observation" which is a Medicare approved account status. If we can broaden this language it will still capture the patient population that was intended in this section without having to consider what type of financial account/status this patient will have while under the direct care of the inpatient hospital. Solution: Reword the two sections to state : 1751.2 (a) "The telephone number is not required on the label for sterile drug preparations dispensed to patients who are physically under the direct care of the facility."
1751.2(a)	**Barcon & Associates** Douglas Barcon, Pharm.D	There appears to be a typo in this paragraph. Recommendation: Change to "Telephone number, except on the label for sterile drug preparations dispensed to inpatients by a hospital pharmacy."

Code Section	Commenter	Comment
1751.2(b)	**Providence Heath & Services Southern California Region**	Name and concentration **or strength, volume or weight** of each **active** ingredient contained in the sterile **compounded** drug preparation. Request clarification on this requirement for "each ingredient:" - Are inactive ingredients required on the label? - If inactive ingredients are required on the label, please exclude inactive agents used to reconstitute a powder vial (e.g., sterile water) that will be further diluted in solution for the sterile compounded drug preparation. If sterile water appears on the label of the compounded sterile drug preparation, it would be confusing for those reading the label since the sterile water for reconstitution is not part of the prescription or drug order and of no clinical significance to the patient. - Providence recommends that each active ingredient be required on the label and the only inactive ingredient(s) required should be the final diluent solution used to dilute the sterile compounded preparation's active ingredient. This would be consistent with the modified language proposed in 1735.1(ae). - 1735.1(ae) implies that only active ingredients are listed on the label and inactive ingredients do not have to be listed on the label because they are in the compounding log: (d)(w)(ae) "Quality" means the absence of harmful levels of contaminants, including filth, putrid, or decomposed substances, and the absence of active ingredients other than those listed on the label, and the absence of inactive ingredients other than those listed noted on the compounding log label. - 1735.4(c) requires the name(s) of the active ingredient(s) only. It does not require the inactive ingredients as well. - Sterile compounded drug preparations are prepared in single-dose containers or unit-dose containers and each ingredient would not fit on the label if inactive ingredients were also required.
1751.2(b) Continued	**Providence Heath & Services Southern California Region**	Providence also recommends changing the requirement of the concentration on the label to include the strength, volume or weight of the ingredient(s). - This would be consistent with labeling requirements from 1735.4(c) that require the name of the active ingredient(s), strength, volume or weight of the preparation. - B&PC 4076 requires only the strength of the drug. - If the active ingredient dose or strength is on the label and the final volume of the diluent is also on the label, then the concentration should not be required. Most drugs that are sterile compounded preparations are prescribed, ordered and prepared as the drug dose only (not the concentration). For example, prescribers order Vancomycin 1 gram IV once. The current labels typically will state the drug name, dose, and volume and name of the appropriate diluent: "Vancomycin 1 gram in 200ml of Normal Saline." This is much more clear and accurate than if the label were to state vancomycin 5mg/ml which is the concentration. Finally, we recommend adding "compounding" to clarify that labeling requirements only apply to sterile compounded drug preparations and not to other sterile drug preparations that are not compounded.
1751.2(d)	**Mercy General Hospital** Jeffrey Nehira	Cytotoxic and Hazardous drugs have very specific definitions not necessarily interchangeable. Prior to changing this in the CA Pharmacy law, I suggest waiting for the publication of USP800.

Code Section	Commenter	Comment
1751.3(a)(1)	**Providence Heath & Services Southern California Region**	Compounding, filling, and labeling of sterile **compounded** drug preparations.
1751.3(a)(11)	**Pacific Compounding Pharmacy** Marie Cottman	Comments: Why are solutions being singled out? High risk compounders are also making gels, suspensions, etc from non-sterile components. It should not be necessary to have a Policy and Procedure to address a process that should be clear and concise in a Master Formulation Record. Recommendation: remove section R as the preparation of this type of sterile preparation should be addressed adequately in the Master formula required elsewhere.
1751.3(a)(17)	**Mercy General Hospital** Jeffrey Nehira	See comment for: 1735.5 (c)10 above. Guidance on humidity monitoring should be provided.
1751.3(a)(17)	**Kaweah Delta Medical Center** Rheta Sandoval, Pharm.D.	Insert the words “within the pharmacy” after the word “area” to be consistent with 1735.5 (c)(10) and 1735.5 (c)(11).
1751.4(d)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Consider a typical scenario in a clean room in a hospital pharmacy. During a 15-minute period of compounding operations, pharmacy personnel could compound four doses of azithromycin 500 mg/250mL dextrose 5% for four different patients, two doses of famotidine 40 mg in 250mL dextrose 5% 250mL for one patient, and five doses of furosemide 100mg/100mL dextrose 5% for five different patients. Under the definition of “lot”, pharmacy personnel would be required to clean and disinfect the ISO Class 5 PEC before and after each lot – four times in 15 minutes. If one considers the number of lots that would be compounded in four hours, the PECs would need to be cleaned and disinfected 50 to 60 times. We therefore recommend that 1751.4(d)(2) be deleted. Subsections 1751.4(d)(1) , 1751.4(d)(3) , and 1751.4(d)(4) are sufficient.

Code Section	Commenter	Comment
1751.4(d)	**California Society of Health-System Pharmacists** Dawn Benton	Recommendation: Modification recommended as follows: 1751.4 (d) (1) at the beginning of each shift; (2) ~~before and after each lot~~ every 30 minutes during the compounding period; (3) at the end of each compounding period; (4) after each spill; and (5) when surface contamination is known or suspected.
1751.4(d)(2)	**Kaweah Delta Medical Center** Rheta Sandoval, Pharm.D.	Cleaning and disinfecting surfaces of the ISO Class 5 PEC before and each lot (per the proposed definition) may not be feasible depending on the scale of operations. There could be interference with timely medication preparation and dispensing and significant operational impacts. For pharmacies that are preparing upwards of 60,000 dosage units annually, 5 minutes or more spent cleaning and disinfecting surfaces in the ISO 5 PEC before and after compounding each dosage unit would have a definite impact on operations and costs. USP and ASHP Guidelines on Compounding Sterile Preparations requires cleaning and disinfecting before each batch, with a “batch” defined differently then the BOPs proposed definition of “lot” resulting in a frequency that is more realistic while maintaining adequate safeguards against microbial contamination.
1751.4(d)(2)	**Mercy General Hospital** Jeffrey Nehira	According to the definition of lot listed above, cleaning and disinfection of an ISO-5 surface would occur following one or more compounded drug preparation(s) prepared during one uninterrupted continuous cycle of compounding from one or more common active ingredient(s). This is impractical for a hospital setting which may utilize more than 1 person compounding on the ISO-5 surface. Barrior isolators, MICs, and Laminar Flow hoods are all built for use by more than 1 person at a time. Recommend removing this requirement and leaving it up to the judgment of licensed personnel engaged in compounding, "when surface contamination is known or suspected".
1751.4(d)(2)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: The most recent USP 797 regulations state that cleaning of the ISO 5 PEC should occur at the beginning of each work shift, before each batch (USP 797 only uses the word batch in referencing high-risk compounding) preparation is started, every 30 minutes during continuous compounding periods of individual CSPs, when there are spills, and when surface contamination is known or suspected from procedural breaches. With the new proposed definition of “lot,” interruption of workflow of hospital compounding in order to clean before and after each lot may impact the timeliness of medication delivery to patient and could introduce potential for medication errors. Solution: Remove “before and after each lot” and replace with “every 30 minutes during continuous compounding.”

Code Section	Commenter	Comment
1751.4(e)	**Providence Heath & Services Southern California Region**	Counters, and cleanable work surfaces and floors shall be cleaned with a germicidal detergent and water and disinfected with a suitable agent daily. Floors in the buffer or clean area, ante-area, and segregated compounding area are cleaned by mopping with a cleaning and disinfecting agent once daily at a time when no aseptic operations are in progress. Providence recommends adding USP 797 wording for floor cleaning requirements. The current proposed wording of this section requires a three- step cleaning for floors which UPS 797 does not require (a germicidal detergent and water and a disinfecting agent). If a single cleaning agent both cleans and disinfects it can be used alone according to USP 797. Water is not required separately for floor cleaning and a separate disinfecting agent is not required.
1751.4(e)	**California Hospital Association** BJ Bartleson	Add the italicized to section (e) to clarify what gets what type and what frequency of cleaning. *"Counters, tables and cleanable work surfaces shall be cleaned with a germicidal agent, rinsed with sterile water and disinfected with a suitable agent daily. Floors are cleaned with a germicidal agent and rinsed with water daily. Walls ceilings, storage shelving and stools are cleaned with a germicidal agent and rinsed with water monthly.*
1751.4(e)	**Cedars-Sinai** Katherine Palmer Rita Shane	Counters, cleanable work surfaces and floors shall be cleaned with **sterile water and disinfected with a suitable germicidal agent daily** ~~germicidal detergent and water and disinfected with a suitable agent daily~~. Language modified to be consistent with USP 797.
1751.4(e)	**California Society of Health-System Pharmacists** Dawn Benton	Recommendation: Concordance with USP 797 language. Use of isopropyl alcohol for floors, ceilings and walls would be dangerous. Modification recommended as follows: 1751.4 (e) Exterior workbench surfaces and other hard surfaces in the designated area, such as walls, floors, ceilings, shelves, tables, and stools, must be disinfected weekly and after any unanticipated event that could increase the risk of contamination. Counters, cleanable work surfaces and floors shall be cleaned with a suitable agent for cleaning and disinfection ~~germicidal detergent and water and disinfected with a suitable agent (e.g., sterile isopropyl alcohol)~~ daily. Walls, ceilings, storage shelving, tables and stools shall be cleaned with a suitable agent for cleaning and disinfection ~~germicidal detergent and water and disinfected with a suitable agent (e.g., sterile isopropyl alcohol)~~ monthly. Cleaning and disinfecting shall occur after any unanticipated event that could increase the risk of contamination.
1751.4(e)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Recommendation: Remove "(e.g., sterile isopropyl alcohol)" Rationale Cleaning large surface areas, such as floors with Isopropyl alcohol, which is highly flammable, can create a substantial fire hazard which would be especially dangerous in hospitals and patient care areas. Using "sterile isopropyl alcohol" widely is also very costly without justification for certain surfaces. Daily cleaning of floors with a non-flammable agent is reasonable.

Code Section	Commenter	Comment
1751.4(f)	**Mercy General Hospital** Jeffrey Nehira	Recommend updating the second sentance to state, “Certification and testing of primary and secondary engineering controls shall be performed no less than every six months. Certification and testing will also occur whenever the device or area designated for compounding is altered or a service to the facility is performed that would impact the device or area.” Barrier isolators are self-contained by definition and manufacturer specification and should not require recertification if moved.
1751.4(f)	**Barcon & Associates** Douglas Barcon, Pharm.D	Rationale: This section did not specify certification by the manufacturer that the CAI or CACI is compliant with USP 797 if used in a non-ISO classified room or outside of an ISO Class 7 buffer area nor did it address compliance with regulation 1751.4(h) as an alternative. Linking 1751.4(f) to 1751.4(h) would be appropriate to avoid misinterpretation. Recommendation: Renumber (1) through (3) as (2) through (4) and insert the following as the new number (1): (1) compliant with 1751.4(h) of Title 16, Division 17, of the California Code of Regulations. Alternative wording for the new number (1) could be: (1) the manufacturer has certified the compounding aseptic isolator or compounding aseptic containment isolator to be compliant with USP 797 during dynamic operation conditions for use in a non-ISO classified room or outside of an ISO Class 7 buffer area. However, this alternative could add confusion to 1751.4(h). Due to the close relationship between 1751.4(f) and 1751.4(h), wording in modifications to one affects the other and can weaken or strengthen both. Mixing and matching comments from multiple individuals on these two regulations may have unintended effects
1751.4(f)(1)	**Mercy General Hospital** Jeffrey Nehira	This secton requires clarification and exemption should be made for Barrior Isolators for this requirement as the airflow displacement is different than laminar flow hoods. The requirements for measuring the particle counts apply to lamnar flow hoods.
1751.4(f)(2)	**Mercy General Hospital** Jeffrey Nehira	Recommend clarification of this requirement. If this is requiring testing of Barrior Isolators during material transfer this is impracticle and not part of testing for recertification of the hoods.
1751.4(f)(3)	**Mercy General Hospital** Jeffrey Nehira	Recommend clarification of this requirement. If this is requiring testing of Barrior Isolators during material transfer this is impracticle and not part of testing for recertification of the hoods. Barrior isolators have manufacturer recommended purge times prior to aseptic manipulation. Perhaps this regulation should defer to manufacturer specifications.

Code Section	Commenter	Comment
1751.4(g)	**Mercy General Hospital** Jeffrey Nehira	Request exemption of the labeling requirement for DSH hospitals and rural hospitals as this places a tremendous cost on the organization/facility. The third sentence states that during hazardous compounding performed using a compounding asceptic containment isolator full garbing must occur, which includes two layers of gloves... this contradicts some manufacturers recommendation of mobile isolation chamber use. This also does not correspond to the ASHP recommendations of Hazardous Drug Preparation. Clarification needs to be made since manufacturers recommend an intermediary cloth glove that allows for easy removal of the hand from the containment glove. Please note that most sterile gloves do not meet ASTM 6978-05 and those that are used for chemotherapy handling that most facilities utilize are typically the non-sterile nitrile gloves.
1751.4(g)	**Providence Heath & Services Southern California Region**	Pharmacies preparing sterile hazardous agents shall do so in accordance with Section ~~505.12.1~~ 505.5.1 of Title 24,**Part 4**, Chapter 5, of the California Code of Regulations, In the board response to comments, staff agreed with our recommendation to amend Section 1751.4(g) to accurately reflect the citation of the 2013 California Building Standards Code.
1751.4(g)	**Valley Children's Hospital** Richard Sakai	Any drug preparation…….are considered hazardous unless the hazardous drug PEC has been decontaminated. If the IV hood has been properly decontaminated non-hazardous drugs may be compounded in the IV hood.
1751.4(g)	**California Hospital Association** BJ Bartleson	Change the section references starting on page 28 from, "Pharmacies preparing sterile hazardous agents shall do so in accordance with Section 505.12.1 of Title 24, Chapter 5, of the California Code of Regulations", to *Pharmacies preparing sterile hazardous agents shall do so in accordance with Section 505.5.1 of Title 24, Part 4, Chapter 5, of the California Code of Regulations*. This more accurately reflects the citation of the 2013 California Building Standards Code. Delete the last sentence in the paragraph that states, "Where the documentation provided by CACI manufacturer does not require garbing only the two glove requirement shall apply. There is confusion regarding the CAI, where garbing is for patient safety and requires less than full garb, and CACI where this is protection for the operator and requires full garb
1751.4(g)	**Pacific Compounding Pharmacy** Marie Cottman	Comments: Please re-review Section 505.12 of Title 24, Part 4, Chapter 5 of the California Code of Regulations, as it is NOT current! It has been renumbered to 505.5.1 in the 2013 edition of the Mechanical Code. Reference: 2008 version http://www.iapmo.org/Code%20Errata/2007%20California%20Mechanical%20Code%20Errata/2007-CMC-Errata%20010208.pdf 2013 version: http://www.iapmo.org/2013%20California%20Mechanical%20Code/Chapter%2005.pdf

Code Section	Commenter	Comment
1751.4(h)	**Barcon & Associates** Douglas Barcon, Pharm.D	This paragraph appears to be an extension of 1751.4(f) without a link for clarity in 1751.4(f). Also, 1751.4(h) failed to include a compounding aseptic containment isolator and make clear manufacturer certification for placement into a non-ISO classified room is necessary. Recommend to change first sentence to: If a compounding aseptic isolator or compounding aseptic containment isolator is certified by the manufacturer to maintain ISO Class 5 air quality during dynamic operation conditions during compounding as well as during the transfer of ingredients into and out of the compounding aseptic isolator or compounding aseptic containment isolator in a non-ISO classified room, then it may be placed into a non-ISO classified room. The recommended change to the first sentence could be further modified by adding “comply with USP 797 and” between “to” and “maintain”.
1751.4(h)	**Mercy General Hospital** Jeffrey Nehira	This statement says when using a compounding asceptic containment isolator full garbing must occur, which includes two layers of gloves... Two layers of gloves are not consistent with most PEC operational guidelines and deviate from manufacturer recommendations. Clarification needs to be made since manufacturers recommend an intermediary cloth glove that allows for easy removal of the hand from the containment glove. Donning of sterile gloves with asceptic islolators also does not make sense since the outside portion of the glove and the barrior isolator can be maintained in a non- sterile environment.
1751.4(i)	**California Hospital Association** BJ Bartleson	Replace wording to read, “*The pharmacy must identify the CFU’s to the genus level in addition to conduction an investigation. When environmental monitoring action levels are exceeded, the pharmacy shall include an immediate investigation of cleaning and compounding operations and facility management*. Confusion exists regarding the USP 797 language but CFU’s must be identified so the facility is aware of the resident bacteria
1751.4(i)	**California Society of Health-System Pharmacists** Dawn Benton	Is it the intent of the Board of Pharmacy that identification of CFUs is only required when the environmental monitoring action levels are exceeded? USP<797> states that indicates for CFUs captured via impaction air sampler will be “identification of microorganisms recovered (at least the genus level)…”

Code Section	Commenter	Comment
1751.4(i)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Recommendation: Adopt the language in USP Chapter 797 for the frequency of the sampling plan, e.g. “Environmental sampling shall occur as part a comprehensive quality management program and shall occur minimally under any of the following conditions: 1. As part of the commissioning and certification of new facilities and equipment 2. Following any servicing of facilities and equipment 3. As part of the re-certification of facilities and equipment, at least every 6 months 4. In response to identified problems with compounded preparation or staff technique 5. In response to issues with CSPs, observed compounding personnel work practices, or patient-related infections (where the CSP is being considered as a potential source of the infection).” Rationale: The frequency of sampling is over burdensome and without merit scientifically.
1751.4(j)	**Mercy General Hospital** Jeffrey Nehira	The requirement of a <20 degree C room temperature for compounding sterile preparations is in conflict with the definition of controlled room temperature defined above. ("Controlled room temperature" means 20 degrees to 25 degrees C9 68-77 degrees F.) If medications are stored in a preparation area that is monitored in accordance to the above defined guidelines, and if temperature is to be maintained throughout preparation, this requirement is not attainable. Please clarify.
1751.4(j)	**California Society of Health-System Pharmacists** Dawn Benton	Many hospitals in California do not have AC in the pharmacy. Requiring temperatures of 68 degrees Fahrenheit or cooler will require some phase-in period.
1751.4(j)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: The most recent USP 797 regulations state that viable surface sampling be done periodically. Many hospitals conduct surface sampling every six months to coincide with the requirements for PEC and cleanroom certification. Pharmacies may also not have access to qualified individuals every quarter for surface sampling, but would have access to these qualified individuals every six months for the PEC and cleanroom certifications. Solution: Reduce the viable surface sampling requirement to every six months to coincide with other sampling that will be performed by qualified outside vendors.

Code Section	Commenter	Comment
1751.4(j)	**California Pharmacist Association** Brian Warren	The structure of the working environment standards in Section 1751.4(j) do not contemplate compounding pharmacies using exclusively compounding aseptic isolators and/or compounding aseptic containment isolators. Some of these PECs do not require full garbing. If a compounding pharmacist is not wearing full garbing, the proposed temperature of 20 degrees Celsius may be uncomfortably cold for that pharmacist. We recommend allowing for different temperatures when pharmacists are not wearing full garbing. (j) The pharmacy shall have a comfortable and well-lighted working environment, which includes a room temperature of 20 degrees Celsius (68 degrees Fahrenheit) or cooler to maintain comfortable conditions for compounding personnel when attired in the required compounding garb. A room temperature of 20 degrees Celsius (68 degrees Fahrenheit) need not be maintained when garbing is not required because of the use of a compounding aseptic isolator or compounding aseptic containment isolator. ~~Humidity levels should be consistent ASHRAE Standard 55 (30-65% RH).~~
1751.4(j)	**Barcon & Associates** Douglas Barcon, Pharm.D	Rationale: This paragraph was sourced from USP 797 in USP 37-NF 32 May 1, 2014 or an earlier version in the section on Facility Design and Environmental Controls but was misquoted. It actually pertains to the compounding facility or cleanroom where compounding is performed; not the pharmacy. Comfortable conditions are one facet of this temperature specification. Higher temperatures increase perspiration when compounding staff are properly garbed, increase the chance of sterile product contamination from sweat, and increase the chance of compounding errors. Some CACIs do not require wearing protective garb to be compliant. Recommendation is to change this paragraph to: (j) The pharmacy cleanroom or sterile compounding area where compounding staff must wear protective garb to compound shall have a comfortable and well-lighted working environment, which includes a room temperature of 20 degrees Celsius (68 degrees Fahrenheit) or cooler to maintain comfortable conditions for compounding personnel when attired in the required compounding garb.
1751.5(a)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	(6) Recommend changing wording to: “Individuals with “exposed” rashes, sunburn…” Rationale: If the conditions are not exposed, a contamination problem is not realistic.

Code Section	Commenter	Comment
1751.5(a)(1)	**Mercy General Hospital** Jeffrey Nehira	"...unless the compounding aseptic isolator or compounding aseptic containment isolator manufacturer can provide written documentation, based on validated environmental testing, that any component of the personal protective equipment or personnel cleansing are not required." Recommend removal of this statement since the use of any PEC should be according to manufacturer specification. PECs go through a certification process and manufacturered accordingly. Products are sampled using these PECs and environmental testing is done by the pharmacy every 6 months according to the manufacturer recommendations. Manufacturers would not take on the liability of the product since it is dependent on the environment they are used. The environmental sampling done every 6 months should validate the necessity for PPE beyond manufacturer recommendation.
1751.5(a)(4)	**Mercy General Hospital** Jeffrey Nehira	Request clarification needed regarding sterile gloves. Gloves can be donned that are non-sterile and then sterilized prior to compounding sterile preparations. Barrier isolator gloves are also non-sterile and become sterile once disinfected during the cleaning process.
1751.5(a)(6)	**Mercy General Hospital** Jeffrey Nehira	Recommend removing this sentence and replacing with more general language regarding appropriate health of the individual preparing CSPs. Barrier isolators are contained and containers of products are disinfected prior to preparation. Exemptions should be made for urgent and emergent settings in DSH and rural hospitals where compounding may be required by individuals with minor sunburns.
1751.7(b)	**Pioneers Memorial** John Teague	it states on the top of page 35 “promoted growth”, but it should say “promote”
1751.7(c)	**Pioneers Memorial** John Teague	if a facility has a CAI or CACI that is not required to be placed in an ISO7 environment how are they to complete the fingertip testing? I think it needs to elaborate more on the fact that sterile gloves must be worn within the CAI and CACI and that would obviously be where the gloves would be tested. It wouldn’t make sense to garb up and test fingertips in an area that doesn’t have ISO certification.
1751.7(e)	**Hartley Medical** William Stuart	Recommend distinguishing non-sterile-to-sterile drug preparations that are batches and patient-specific preparations. The time required to test for sterility for patient-specific is cost-prohibitive and disruptive to providing adequate patient care and safety. Consider exempting patient specific preparations from testing due to urgency of treatment.

Code Section	Commenter	Comment
1751.7(e)	**California Pharmacist Association** Brian Warren	~~(c)~~ (e) ~~Batch-produced sterile injectable drug products preparations compounded from one or more non-sterile ingredients~~ Non-sterile-to-sterile drug preparations that meet the criteria in paragraph (1) or (2), below, shall be subject to documented end product testing for sterility and pyrogens ~~that are exposed longer than 12 hours at 2 to 8 degrees C and longer than 6 hours at warmer than 8 degrees C before they are sterilized shall meet the sterility test in accordance with methodologies and processes found in Chapter 71 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), and testing for pyrogens in accordance with the methods of Chapters 85 and 151 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference,~~ and shall be quarantined until the end product testing confirms sterility and acceptable levels of pyrogens, per USP chapter 85 limits, before dispensing. This requirement of end product testing confirming sterility and acceptable levels of pyrogens prior to dispensing shall apply regardless of any sterility or pyrogen testing that may have been conducted on any ingredient or combination of ingredients that were previously non-sterile. (1) Non-sterile-to-sterile drug preparations that are prepared in groups of more than 25 identical individual single-dose packages for administration to multiple patients. (2) Non-sterile-to-sterile drug preparations that are exposed longer than 12 hours at 2 degrees Celsius to 8 degrees Celsius or longer than 6 hours at warmer than 8 degrees Celsius before they are sterilized. We recommend the above changes to maintain consistency with USP <797> standards. As Section 1751.7(e) is currently written, and as “non-sterile-to-sterile batch” is defined in Section 1735.1(v), all non-sterile-to-sterile preparations would be required to undergo end-product testing for sterility and pyrogens. However, this is inconsistent with USP <797> and would result in unnecessary delays for patients and an increase in the cost of compounded sterile preparations. USP <797> requires all non-sterile-to-sterile preparations (which it refers to as “high-risk level CSPs”) to be assigned a restricted beyond use date (24 hours at controlled room temperature, 3 days at controlled cold temperature, and 45 days at controlled freezer temperature) unless end-product testing is performed that justifies a more extended beyond use date. In addition to the restricted BUD requirement, USP <797> requires some but not all non-sterile-to-sterile preparations to undergo end-product testing. End-product testing is always required for (1) non-sterile-to-sterile preparations that are prepared in batches of more than 25 and (2) non-sterile-to-sterile preparations that are exposed longer than 12 hours at 2 degrees Celsius to 8 degrees Celsius or longer than 6 hours at warmer than 8 degrees Celsius before they are sterilized

Code Section	Commenter	Comment
1751.7(e) (Continued)	**California Pharmacist Association** Brian Warren	The Board's proposed regulations, as modified, adopt some but not all of the USP <797> standards applicable to sterile-to-non-sterile preparations. Section 1751.8(c) requires non-sterile-to-sterile preparations to be assigned a restricted beyond use date unless end-product testing is performed that would justify a more extended beyond use date. This is consistent with USP <797> standards. However, Section 1751.7(e) requires all non-sterile-to-sterile preparations to undergo end-product testing, which as described above, is not consistent with USP <797>. USP <797> standards are based on the most up-to-date scientific information available and written by top experts in the field. As USP states, the objective of chapter <797> is to prevent patient harm. We are aware of no clinical or other scientific evidence that justifies end-product testing requirements exceeding those outlined in USP <797>. Further, the Board has failed to produce any scientific evidence to suggest a rational basis for requiring universal end-product testing for all non-sterile-to-sterile preparations. As stated in the Board's Initial Statement of Reasons, the justification for changes to this section is to address "the problem of ensuring that board regulations are aligned with compounding standards in USP 37 <797> and reducing such discrepancy for the compounding profession who are compounding drug products in California and shipping into California so as to ensure the safety of all consumers receiving compounded drugs in California." As currently drafted, the Board's proposed regulation is not in alignment with USP <797>, and could negatively impact patients due to delays in availability of non-sterile-to-sterile preparations and increases in the cost of non-sterile-to-sterile preparations. In fact, if the Board were to adopt its proposed regulation as-is, there would be no legal means for any patient to receive any non-sterile-to-sterile preparations before end-product testing results are first obtained, even if that drug preparation would prevent loss of life or intense suffering. The modifications recommended above will keep the Board's regulations in alignment with USP <797> to protect patient safety and ensure continued availability of lifesaving medications.

Code Section	Commenter	Comment
1751.7(e)	**Precision Pharmacy** Rachel Taggs	As worded this would require pyrogen testing on all ophthalmic and inhalation solutions. Ophthalmics and inhalation solutions are excluded from pyrogen testing according to USP. USP <797>: All high-risk level CSPs, except those for inhalation and ophthalmic administration, that are prepared in groups of more than 25 identical individual single- dose packages (e.g., ampuls, bags, syringes, vials) or in MDVs for administration to multiple patients or that are exposed longer than 12 hours at 2° to 8° and longer than 6 hours at warmer than 8° before they are sterilized shall be tested to ensure that they do not contain excessive bacterial endotoxins. Sterility testing all non-sterile to sterile batches Some compounded preparations are only stable for a short length of time. For example, if a preparation is only stable for 14 days (or less), requiring a 14 day sterility test would inhibit the ability to provide adequate treatment. USP allows for short BUDs for preparations that have not been sterility tested. As also referenced in 1751.8; which contradicts the testing requirement in 1751.7(e). USP <797> - For a sterilized high-risk level preparation, in the absence of passing a sterility test, the storage periods cannot exceed the following time periods: before administration, the CSPs are properly stored and are exposed for not more than 24 hours at controlled room temperature (see General Notices and Requirements), for not more than 3 days at a cold temperature (see General Notices and Requirements), and for 45 days in solid frozen state between −25° and −10°. [NOTE—Sterility tests for autoclaved CSPs are not required unless they are prepared in batches of more than 25 units.]
1751.7(e)	**Precision Pharmacy** Rachel Taggs	Initially proposed language allowing for emergency released preparations would allow for patient treatment to continue when needed in the extreme circumstances where failure to dispense would result in loss of life or intense suffering. For example, an eye drop to treat a resistant fungal infection, would only be needed in an emergency situation when other antifungals are not able to treat the infection. In the veterinary marketplace limited treatment options are available.
1751.7(e)	**Pacific Compounding Pharmacy** Marie Cottman	Comments: This is in conflict with USP <797> recommendations for testing ALL sterile products for sterility AND pyrogens. USP <797> specifically exempts ophthalmic drops and inhalations from testing for pyrogens. Recommendation: Clarify that pyrogen testing is for sterile INJECTABLE drugs. Also allow for other industry standard testing for sterility other than USP <71> as the RDI testing is superior to USP <71>. Reference: Referenced USP <797> High Risk Sterile Compounds Sterility Testing and Bacterial Endotoxin (Pyrogen) Testing

Code Section	Commenter	Comment
1751.7(e)	**Harbor Compounding Pharmacy** Mai Tran Sam Kitahara	Performing sterility and endotoxin test for a single unit of non-sterile-to-sterile drug preparation is very cost prohibited and it will delay the time the patient can benefit from the therapeutic effects of the sterile compound. Especially for uncommon strengths that is very patient specific and will not be used for anyone else. The premises of compounding is to fit the unique need of the patient and by defining batch as 1 or more will make these types of preparations very unaffordable and unavailable for patients. This will create unnecessary burden for a pharmacy that has a proven track record (via documented process validations) for compounding high risk preparation successfully. Recommendation: Non-sterile-to-sterile batch drug preparations shall be subject to documented end product testing for sterility and pyrogens and shall be quarantined until the end product testing confirms sterility and acceptable levels of pyrogens, per USP Chapter 85 limits, before dispensing. See recommendation in section 1735.1 (v) for “non-sterile-to-sterile batch” definition.
1751.7(e)	**Harbor Compounding Pharmacy** Mai Tran Sam Kitahara	"...shall apply regardless of any sterility or pyrogen testing that may have been conducted on any ingredient or combination of ingredients that were previously non-sterile." This verbiage is very confusing. Please clarify. For example: • We have a sterile preparation "Drug A+B" that was compounded from sterile-to-sterile process using Drug A and Drug B. • But both Drug A and Drug B were compounded by the pharmacy from ingredients that was previously non-sterile and were tested/confirmed to pass sterility and pyrogen levels • This verbiage implies that we still need to perform sterility and pyrogen testing for Drug A+B since it came from a source that was previously non-sterile. • Since Drug A and Drug B have confirmed to be sterility and have acceptable levels of pyrogen, shouldn't this be considered LOW RISK sterile compounding? Recommendation: • Please omit this verbiage.

Code Section	Commenter	Comment
1751.7(e)	**Cedars-Sinai** Katherine Palmer Rita Shane	In a circumstance where a sterile drug preparation compounded from one or more non-sterile ingredients is necessary for immediate dispensing where failure to dispense could result in loss of life or intense suffering, (1) Prior to dispensing: (A) Notifying the prescriber of the inability to conduct testing; (B) Suggesting an available alternative product to the prescriber; and (C) Securing the prescriber's and patient's written consent to dispense. (2) And subsequent to dispensing: (A)Send random sample for sterility and pyrogen testing as part of process validation (B) Notify physician if results demonstrate microbial growth or pyrogens (C) Have protocol approved by the Pharmacy & Therapeutics Committee Would recommend including this section back into the regulation revision as to avoid patient loss of life or intense suffering due to the inability to provide emergency medications to patients.
1751.7(e)	**Eagle Analytical Services** William Zolner	It surprises me that the language concerning emergency use of these preparations has been removed from the regulations. It would seem to me that if our highest priority is the well-being of patients, then in the case of possible loss of life or intense suffering prudent discretion could be made for the use of a preparation that may not have fully passed sterility or endotoxin testing. I base this opinion on the following: 1. Sterility testing does not make a compounded preparation sterile. Only a comprehensive sterile process employed in the compounding of the preparation can insure sterility. I often remind pharmacists that you cannot: “Test sterility into a compound, you have to make it sterile”. 2. Process validation of the comprehensive sterile compounding process within a pharmacy is the most important factor in insuring that sterile preparations are in fact sterile and have acceptable levels of bacterial endotoxins. This, in addition to the requirements stated in the original language, should allow for sufficient oversight of these non-standard activities 3. The risk-reward equation for a Pharmacy which has demonstrated a well-documented process validation of their sterile processes and has consistently shown that they can compound sterile preparations is balanced in favor of allowing this exemption, especially in the case of possible loss of life or intense suffering of a patient. I am also concerned about the apparent conflict in the language in this paragraph as it relates to the language in § 1751.8 (c). The Beyond Use Date for the “Non-sterile to sterile” class of sterile preparations is defined as 24 hours at controlled room temperature, 3 days at controlled cold temperature and 45 days at controlled freezer temperature. It would appear that if the sterile preparation cannot be used after these dates in the absence of a sterility test, that they can be used before these Beyond Use Dates. This is the interpretation contained in USP<797> Pharmaceutical Compounding – Sterile Preparations. You may want to clarify this, either by adding language to this paragraph or by inclusion in the previous paragraph.

Code Section	Commenter	Comment
1751.7(e)	**California Specialty Pharmacy** Sumit Desai	In order to ensure consistency with USP Chapter <797>, which establishes evidence-based standards for the compounding of sterile drug preparations, I recommend that CCR Title 16, Section 1751.7 (e) be modified to require non-sterile-to-sterile drug preparations to undergo end-product testing for sterility and pyrogens only when one of the following conditions applies: (1) When non-sterile-to-sterile CSPs are prepared in groups of more than 25 identical individual single-dose packages for administration to multiple patients. (2) When non-sterile-to-sterile CSPs are exposed longer than 12 hours at 2 degrees Celsius to 8 degrees Celsius or longer than 6 hours at warmer than 8 degrees Celsius before they are sterilized Absent falling into one of the above categories, non-sterile-to-sterile CSPs should not be subject to end-product testing, but should be subject to the shortened BUDs indicated in USP <797>. With the above modification, the Board's sterile compounding regulations will closely mirror the standards in USP <797>, ensuring patient safety and timely patient access to compounded sterile preparations
1751.7(e)	**Ann Vu**	In order to ensure consistency with USP Chapter <797>, which establishes evidence-based standards for the compounding of sterile drug preparations, I recommend that CCR Title 16, Section 1751.7 (e) be modified to require non-sterile-to-sterile drug preparations to undergo end-product testing for sterility and pyrogens only when one of the following conditions applies: (1) When non-sterile-to-sterile CSPs are prepared in groups of more than 25 identical individual single-dose packages for administration to multiple patients. (2) When non-sterile-to-sterile CSPs are exposed longer than 12 hours at 2 degrees Celsius to 8 degrees Celsius or longer than 6 hours at warmer than 8 degrees Celsius before they are sterilized Absent falling into one of the above categories, non-sterile-to-sterile CSPs should not be subject to end-product testing, but should be subject to the shortened BUDs indicated in USP <797>. With the above modification, the Board's sterile compounding regulations will closely mirror the standards in USP <797>, ensuring patient safety and timely patient access to compounded sterile preparations

Code Section	Commenter	Comment
1751.7(e)	**Key Compounding** Rachael Vardeman	In order to ensure consistency with USP Chapter <797>, which establishes evidence-based standards for the compounding of sterile drug preparations, I recommend that CCR Title 16, Section 1751.7 (e) be modified to require non-sterile-to-sterile drug preparations to undergo end-product testing for sterility and pyrogens only when one of the following conditions applies: (1) When non-sterile-to-sterile CSPs are prepared in groups of more than 25 identical individual single-dose packages for administration to multiple patients. (2) When non-sterile-to-sterile CSPs are exposed longer than 12 hours at 2 degrees Celsius to 8 degrees Celsius or longer than 6 hours at warmer than 8 degrees Celsius before they are sterilized Absent falling into one of the above categories, non-sterile-to-sterile CSPs should not be subject to end-product testing, but should be subject to the shortened BUDs indicated in USP <797>. With the above modification, the Board's sterile compounding regulations will closely mirror the standards in USP <797>, ensuring patient safety and timely patient access to compounded sterile preparations
1751.8	**Mercy General Hospital** Jeffrey Nehira	his section of Title 16 seems to try and copy the definitions of low, medium, and high risk compounding. Recommend using verbiage straight from USP797 to eliminate confusion.
1751.8	**California Society of Health-System Pharmacists** Dawn Benton	The Beyond Use Date for patient specific allergenic extracts, ie, subdermal injections for a single patient, from a vial is 12 months.
1751.8	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Recommendation: Add language to allow for beyond use dates longer than USP 797 default beyond use dates if specified in the manufacturer's FDA-approved labeling, e.g. Allergy Extract Injections

Code Section	Commenter	Comment
1751.8(a)(1)	**Providence Heath & Services Southern California Region**	Where the sterile compounded drug preparation was compounded solely with aseptic manipulations (1) entirely within an ISO Class 5 PEC ~~located in an ISO Class 7 buffer area with an ante- area~~, **or better air quality** The proposed language restricts sterile compounding with USP 797 defined beyond-use dating to only within an ISO 7 buffer area with an ante-area. USP 797 guidelines allow for sterile compounding within a CAI or CACI that meets all of the operational criteria as defined in Section 1751.4(f) and use of beyond-use dating specified. A buffer area and ante-area should not be required. Providence recommends adopting the wording used in USP 797.
1751.8(a)(1)	**Barcon & Associates** Douglas Barcon, Pharm.D	Rationale: 1751.4(f) and 1751.4(h) address compounding aseptic isolators and compounding aseptic containment isolators that do not require placement within an ISO Class 7 buffer area to be compliant. The proposed 1751.8(a)(1) does not address these compliant CAIs or CACIs or manufacturer certification, which should be included in this paragraph. Recommendation: The preparation is compounded entirely within an ISO Class 5 PEC located in an ISO Class 7 buffer area with an ante-area; or within a CAI or CACI in compliance with 1751.4(f) and 1751.4(h) of Title 16, Division 17, of the California Code of Regulations, using only sterile ingredients, products, components, and devices; and
1751.8(b)(1)	**Providence Heath & Services Southern California Region**	Where the sterile compounded drug preparation was compounded solely with aseptic manipulations (1) entirely within an ISO Class 5 PEC located ~~in an ISO Class 7 buffer area with an ante- area~~, **or better air quality** The proposed language restricts sterile compounding with USP 797 defined beyond-use dating to only within an ISO 7 buffer area with an ante-area. USP 797 guidelines allow for sterile compounding within a CAI or CACI that meets all of the operational criteria as defined in Section 1751.4(f) and use of beyond-use dating specified. A buffer area and ante-area should not be required. Providence recommends adopting the wording used in USP 797.

Code Section	Commenter	Comment
1751.8(b)(1)	**Barcon & Associates** Douglas Barcon, Pharm.D	Rationale: 1751.4(f) and 1751.4(h) address compounding aseptic isolators and compounding aseptic containment isolators that do not require placement within an ISO Class 7 buffer area to be compliant. The proposed 1751.8(b)(1) does not address these compliant CAIs or CACIs or manufacturer certification, which should be included in this paragraph. Recommendation: The preparation is compounded entirely within an ISO Class 5 PEC located in an ISO Class 7 buffer area with an ante-area; or within a CAI or CACI in compliance with 1751.4(f) and 1751.4(h) of Title 16, Division 17, of the California Code of Regulations, using multiple individual or small doses of sterile preparations combined or pooled to prepare a compounded sterile preparation that will be administered either to multiple patients or to one patient on multiple occasions; and
1751.8(b)(3)	**Hartley Medical** William Stuart	USP <797> does not define “unusually long duration.” We feel this is ambiguous and should be defined.
1751.8(c)	**Precision Pharmacy** Rachel Taggs	For non-sterile to sterile batches 1751.8 (c) contradicts 1751.7 (e) where all non-sterile to sterile compounded products must pass a sterility and pyrogen test.
1751.8(d)	**Kaweah Delta Medical Center** Rheta Sandoval, Pharm.D.	Recommend delete text “in a laminar air flow workbench or biological safety cabinet”. The PEC is already defined in 1751.8(d)(1) and the current language reads as if the preparation is being stored or exposed in the actual PEC; which I don’t believe was intended.
1751.8(d)(1)	**Hartley Medical** William Stuart	This appears to be applicable to hazardous drugs and chemotherapy preparations. However, that is not explicitly stated.
1751.8(e)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: There is no current language in USP 797 or in the proposed USP 800 that discusses a shorter beyond use date for hazardous medications based on low volume. Solution: Remove section 1751.8 (e) completely.

Code Section	Commenter	Comment
1751.8(e)	**Barcon & Associates** Douglas Barcon, Pharm.D	Compounding a hazardous preparation in a non-negative pressure room has no bearing on the BUD. It only potentially affects the safety of the compounding personnel and others where contaminated air travels. Other paragraphs in 1751.8 address the air quality in the compounding area and PEC and the corresponding BUDs. A hazardous preparation should have the same BUD afforded any non-hazardous sterile preparation. The modification to 1751.8 (a)(1) is necessary to include CACIs. There is no reference as to whether or not the compounding aseptic containment isolator specified in (e)(2)complies with USP 797 in a non-ISO Class 7 room or non-ISO classified room. There is no reference as to the category of air quality within the non-negative pressure room specified in (e)(2). Is the intent of the board of pharmacy to address low volume with this regulation to apply a 12-hour BUD to a sterile compounded hazardous preparation that is compounded within a biological safety cabinet or within a CACI that is not certified by the manufacturer for use in a non-ISO classified room when either PEC is located in a non-negative pressure segregated compounding area that could be in a hospital, clinic, or medical office?
1751.8(e)(3)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Recommendation: Hazardous drugs prepared in a CACI in the environment described should have the standard default USP 797 BUDs assigned (not a maximum of 12 hours). Rationale: Hazardous drugs prepared in a compounding aseptic containment isolator that meets the requirements delineated in 1751.4(f) may be assigned the Beyond Use Dates delineated in 1751.8 (a)(b)(c)
1751.8(f)(1)	**Kaweah Delta Medical Center** Rheta Sandoval, Pharm.D.	Revise the word “places” to “placed”. I believe there is a typo.
1751.8(f)(1)	**Mercy General Hospital** Jeffrey Nehira	Recommendation: add glove box as there is currently no verbiage in this section. Currently this is conflicting with previous statements.

Code Section	Commenter	Comment
1751.8(f)(1)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: Many large health care facilities already employ the use of an "immediate use only" label for reasons other than a 1 hour BUD (e.g. criticality of the drug, cost of the drug, etc.) In addition, other regulatory agencies (i.e. The Joint Commission) have stipulations in existence for labeling "immediate use" sterile products (i.e. medication name, strength, quantity, diluent and volume, expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours). To avoid confusion, it would be beneficial to specifically remove the requirement of labeling the product for "immediate use only" and impose the existing regulation of the expiration time when expiration occurs in less than 24 hours. Solution: Replace the requirement of labeling for "immediate use only" with the exact one hour beyond use date and time.
1751.8(f)(1)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: This section does not stipulate as to whether this applies to all healthcare professionals who are qualified to engage in immediate use sterile compounding drug preparation outside the profession of pharmacy. Solution: Please clarify and insert verbiage to make clear of whether or not this stipulation applies to all professions outside of pharmacy who are qualified to engage in immediate use sterile compounding (e.g. RN).
1751.8(f)(2)	**Community Regional Medical Center** Bruce Lepley	**Reason for Concern:** Other regulatory agencies (i.e. The Joint Commission) have stipulations in existence for one to compound immediate use sterile products which include: "…a delay could harm the patient …**or** the products stability is short. To mitigate risk of confusion we recommend adopting similar language that would accomplish the intent of this section. **Solution:** Reword section to use "a delay could harm the patient" or "the products stability is short".
1751.9(a)	**Mercy General Hospital** Jeffrey Nehira	Exemptions should be made for use during a procedure. Most ampules are used in the operating room and are used on the sterile field.

Code Section	Commenter	Comment
1751.9(b)	**Cedars-Sinai** Katherine Palmer Rita Shane	(b) Unless otherwise specified by the manufacturer, any single-dose container of a compounded sterile drug preparation other than an ampule, such as a bag, bottle, syringe or vial, shall be used in its entirety or its remaining contents discarded within the following time limit, depending on the environment: (1) When needle-punctured in an environment with air quality worse than ISO Class 5, within one (1) hour; (2) When needle-punctured in an environment with ISO Class 5 or better air quality, within six {6) hours; (3) **Closed system transfer devices may be used to extend the beyond use date of single dose vials of chemotherapy to 24 hours or use through the end of the shift, whichever is shorter.** Cancer drugs have been associated with multiple drug shortages and adverse patient outcomes. One research study determined that substitution with cyclophosphamide for mechlorethamine resulted in significantly less efficacy in treatment of children with Hodgkin's lymphoma.2 Additionally, as a result, counterfeit chemotherapy is an area of national concern, until such time as E-Pedigree is available. Closed system transfer devices (CTSD) protect the vial from entry of external bacteria after initial puncture beyond the USP 797 approved 6 hour time limit. It has been shown that one of these systems maintains sterility of the vials to which it is attached for up to 168 hours (7 days). Recommendation: Allowance to use CTSDs with supporting literature to extend the beyond use date of single dose vials of chemotherapy to 24 hours or use through the end of the shift, whichever is shorter. This recommendation is more conservative than the timeframe of 7 days listed in the CTSD study and would assist institutions in conserving scarce chemotherapy medications.

Code Section	Commenter	Comment
1751.9(a), (b), and (c)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Recommendation: Include above language from USP 797 allowing the use of proven technologies with quality assurance procedures (for example, Closed System Transfer Devices) allowing for extension of BUD for single-dose vials. Rationale: One of the hallmarks of USP and Current Good Manufacturing Practices (cGMP) is the ability of entities under the guidelines to be innovative and advance practice with validated processes that differ from the current standards. The advancement of knowledge, technology, and validation processes in a very fluid environment must be allowed to flourish; thus the ability to design programs that meet or exceed current outcomes is essential. The key statement allowing this within the USP 797 is as follows: "The use of technologies, techniques, materials, and procedures other than those described in this chapter is not prohibited so long as they have been proven to be equivalent or superior with statistical significance to those described herein" Published literature supporting the use of technology to extend BUD: Derek M. McMichael: et. al., Utility of the PhaSeal closed system drug transfer device. Am J Pharm Benefits. 2011;3(1):9-16. E. Thomas Carey, et. al., Second look utilization of a closed-system transfer device (PhaSeal). Am J Pharm Benefits. 2011;3(6): 1-18.
1753(a)(5)	**Barcon & Associates** Douglas Barcon, Pharm.D	Unless this change would conflict with other state regulations beyond the scope of the board of pharmacy, consider updating USP from 1995 to USP 37-NF-32 May 1, 2014 or newer.

Code Section	Commenter	Comment
1753(b), (c), and (e)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	For “(b)” Recommend deleting renumbering of 1751.1.1 from this regulatory proposal and considering updating those provisions in a future regulation revisions proposal. Rationale: This is an outdated drug list. For “(c)(1)(C) (C)” Recommend modifying language to “Have a specific treatment protocol “or order” from a prescriber for the administration of each medication contained in the portable container.” Rationale: A prescriber should be able to order a drug that is in the portable container for a use that is different than specified in the facility’s protocol for that drug. For (e) - Recommend this section be reviewed based on current practice (use of electronic health records). Rationale: This section does not consider current practice such as the use of electronic health records and drug classifications. This section appears to be beyond the authority of the Board to dictate procedures in home health agencies and hospices.
No Direct Section Named	**Ray Vella**	I am a pharmacist who works in an outpatient infusion pharmacy that mostly prepares IV meds for oncology patients. We do not dispense oral medications for patients to take home. 100% of the medications dispensed are administered by oncology nurses to patients within hours of preparation and before patients leave to go home. Our operation is much like a hospital pharmacy. I am dismayed by the discrepancy in how outpatient infusion pharmacies are treated compared to hospital pharmacies. Although operations are similar, the Board places a much heavier regulatory burden on outpatient pharmacies. Inpatient pharmacies are exempted from documentation of lot numbers, manufacturers and expirations dates for the ingredients in their CSPs as long as their CSPs are utilized within 72 hours. This has been increased from a previous 24 hours. If the Board feels that this documentation is unecessary for inpatient compounding why is it required for outpatient? This regulatory burden adds to our workload and increases costs. Additionally, technician staff is critical to meet the requirements but we are hampered by the more restrictive outpatient tech to pharmacist ratios. It seems we are caught in a bureaucratic bind because there is no special licensing consideration. Because of reimbursement issues for independent oncology clinics, more infusion centers are being purchased by healthcare networks and the costs to patients are radically elevated as a result. The Board's unfair regulatory burden does not help.
No Direct Section Named	**Providence Heath & Services Southern California Region**	Align with USP 797 guidelines: We urge the board to adopt regulations that align and codify best practices in USP 797, including facility and equipment standards and beyond- use dating for sterile compounded drug preparations

Code Section	Commenter	Comment
No Direct Section Named	**Providence Heath & Services Southern California Region**	Allow reconstitution/dilution of drug products: Amend language to allow compounding using FDA-approved drug products. The current modified language pertaining to “a copy or essentially a copy of one or more commercially available drug products” can be interpreted to prohibit dilution of FDA approved drug products per FDA instructions, if there is a pre-diluted drug product commercially available. The proposed rule may unintentionally favor manufacturers who produce and market drug products that are also available in other forms or are able to be compounded
No Direct Section Named	**Providence Heath & Services Southern California Region**	Labeling active ingredients: Recommend that each active ingredient be required on the label. The only inactive ingredient(s) required on the label should be the final diluent solution used to dilute the sterile compounded preparation’s active ingredient. Amend the requirement of the concentration on the label to include the strength, volume or weight of the ingredient(s)
No Direct Section Named	**Pioneers Memorial** John Teague	Also there was another area that wasn’t completely noted and that was the extension of BUD’s. There should be noted within the P&P that BUD’s cannot be extended or if they can be extended then it should note the process for allowing extensions. I would imagine the process would require emergent need for the patient, notification of the practitioner and patient and either data from the mfg or reputable source and that the data must be documented within the compounding log.

Attachment 3

I. November Hearing

1. There were several comments made at the November 4th Compounding Hearing that were inadvertently missed or misunderstood during the review following the 45-day comment period. These comments must be considered and responded to prior to discussing the second fifteen day comments.

   Two of the comments missed related to the definition of Potency being +/- 10% (1735.1). If a manufactured product is received at +/- 10% and a syringe has a +/- 5%; when used perfectly, the chance of having a potency outside the +/- 10% range is possible. Additionally, it a drug is titrated, the potency may be outside the +/- 10% range. Furthermore, there are FDA approved products that allow for over a +/- 10% range.

   Additionally, there was a comment made requesting to exempt compounding of investigational drugs and Nuclear Pharmacies from the regulations. The commenter also indicated that the regulations were impractical in regards to end product testing and cleaning of the hood (increase the volume to 20 a week or base it on how many products are prepared).

   Finally, a commenter mentioned that section 1751.4 is not consistent with 1751.8. They also indicated that with a barrier isolator that is certified, you can't assign the normal default BUD and recommend an increase for low-volume chemo exemption or increase the limitation to 20 doses a week.

2. Comments received during the hearing that were previously provided to the Board include:

1735.2	Unknown Speaker at Hearing	Conflicts with 1751.8 beyond use dates. Clarification required on whether judgment of pharmacist supersedes 1751.8 limits
1735.2(d)(3)	Gary Horne: Hearing Testimony San Mateo Medical Center	Cannot compound sterile product that is commercially available. Exempt products for one time use for administration within 72 hrs for inpatient.
1735.2(e)	Gary Horne: Hearing	Record keeping burden to list master formula for products that are purchased
1751.7(e)	Marie Cottman: Hearing Testimony	Direct conflict with USP 797 guidelines for testing products. Batch definition USP 71 does not require pyrogen testing on non-injectable products, ie eye drops. Add faster forms of testing (RDI testing)
1751.7(e)(2)(B)	Unknown Speaker at Hearing	Change the wording to pyrogen USP chapter 85 limits as the end point for toxins
1751.9	Unknown Speaker at Hearing	Reconsider limits of use of single use vials and multiple use vial and end dates.

   There were several additional speakers at the hearing; however, they were only highlighting comments that they had previously submitted in writing during the 45-day comment period. Those written comments were all included during the review.

3. On November 4, 2014, the Board held a Compounding Regulation hearing. During that hearing, the Board used an audio recording device to record the comments made by the speakers. As a back-up to the device, a board staff member took notes of each speaker's comments. Unfortunately, half way through the hearing, the batteries of the audio recording device went dead. While a staff member attempted to locate fresh batteries, a speaker provided comments that were not audio recorded; however, they were documented in the notes. It is unclear how much of the hearing was not audio recorded. After batteries were located, the remaining portion of the hearing was audio recorded. On November 7, 2014, the two audio recordings were provided to Ms. Martinez so that the comments could be documented for review by the Board; however, the typed notes were mistakenly not provided and Ms. Martinez was not aware of their existence. Ms. Martinez listened to the recordings and determined that the audio quality was poor. Many of the speakers did not, consistently, speak into the microphone provided and the amount of background noise was excessive. The comments were interpreted based on what could be heard and summarized for Board review. On April 14, 2015, the typed notes were provided to Ms. Martinez and it was determined that four speakers did not have their comments documented accurately for review. These comments are summarized in paragraph one.

II. Most Recent 15-Day Comment Period (Ended March 25, 2015)

1. See Attachment A for Comments

2. Below is a summary of the comments received (within scope) during the second 15-day comment period by section:
    - 1735.1 (d) and (f) – The definition of "buffer area" and "cleanroom" appear to overlap, the air pressure differentials are not listed in both, and a request to remove hazardous and chemotherapy compounds from the definitions.
    - 1735.1(f) – The air pressure differentials are not accurate based on the pending USP 800 modifications.
    - 1735.1(g) – The definition of "CAI" is confusing and should not be used to compound antineoplastic hazardous drugs (per USP 800).
    - 1735.1(j) – Commenter states that there cannot be two definitions for a "Controlled Freezer Temperature"
    - 1735.1(r) – Modification is needed to provide guidance to PICs with respect to hazardous drugs that are not anti-neoplastic agents
    - 1735.2(c)(3) – Attempting to make a 72 hr or 120 hr sterile preparation for vet patients will put patients at risk for infections and is not cost effective. Additionally, making patients wait 14 day for sterility testing is not beneficial to the patient.
    - 1735.8(e) – Require out of range temperatures in the pharmacy and patient care areas be addressed in the QA.
    - 1751.4(g) – Remove the double glove requirement for hazardous compounding.
    - 1751.7(e) – Quarantined sterile preparations for test results and not allowing for emergency release will jeopardize patient safety. This will also cause the price of sterile compounds to increase and delay treatment. Additionally, a commenter

requested that pyrogen testing be restricted to injectable drugs only and that the language be clarified as it is confusing as to whether a compound needs to pass sterility testing if both compounds used to make it already passed sterility testing.

- 1751.8(a) and (b) – Questions were raised about the definition of end-user and multiple patients/multi-use containers. Additionally, why doesn't section a apply to those defined in section b.

3. The comments are currently being reviewed and an update will be provided at the Board Meeting.

III. Current Clean Language

As the compounding regulation language has been changed several times and the changes are becoming difficult to read, the board wishes to ensure that all interested parties have a clear understanding of the current language. The language was cleaned up to remove all the underscoring, strike-out, and color from the document. This is the current language approved by the Board at the March 9th Board meeting.

See attachment B for the current clean language

IV. Proposed Changes to the Current Language will be discussed at the Board Meeting.

Attachment A

Code Section	Commenter	Comment
1735.1(b)	**Lauden Integrative Pharmacy** Brian Horan	PCAB standards state that sterility testing of high risk preparations is preformed in accordance with USP Chapter <71>. USP Chapter <71> Sterility Tests defines in "Table 3" the minimum number of articles to be sterility tested in relation to the number of articles in a "batch." Referencing the table, batches of "not more than 100 containers" must have "10% or 4 containers tested, whichever is greater." Our interpretation has been that, in this context, a "batch" could equal a single preparation for a single patient, and that for every one preparation compounded, 4 additional preparations must be compounded during the same continuous cycle of compounding, solely for the purposes of sending them away for 3rd party sterility testing. If we want to make 1, we actually have to make 5. This has been a frustrating reality to deal with because we are a small independent community compounding pharmacy, not a manufacturer. We only dispense a few parenteral preparations each month. However, the word "batch" is proposed to be defined in 1735.1 (b) as being 2 or more finished drug preparations compounded during the same continuous cycle of compounding. 2 or more. Considering this definition, I'm curious if we'd still be held to USP <71> rules for sterility testing a "batch" of one. Otherwise, 80% of our sterile preparations (4 out of 5) are sent for testing instead of sent to patients. Thanks for your patience with this question and I'd be happy to explain our problem further if I'm not being very clear.
1735.1(d)	**Mercy General Hospital** Jeffrey Nehira	Recommend using USP<797> definition of buffer area to prevent confusion and standardize practice, "Buffer Area-An area where the primary engineering control (PEC) is physically located. Activities that occur in this area include the preparation and staging of components and supplies used when compounding.

Code Section	Commenter	Comment
1735.1(d)	**Barcon & Associates** Douglas Barcon	Correct typo: “fron” should be “from” Change “The principle of displacement airflow shall be employed” to “Instead of physical separation from the ante-area, the principle of displacement airflow shall be employed.” Without such a change, the regulation states that a buffer area could only use displacement airflow, which is incorrect. Alternatively, change “The principle of displacement airflow shall be employed” by adding after employed: “where there is no physical separation from the ante-areas by walls or doors. To improve the definition of a “buffer area”, change the first sentence to: “ “Buffer area” means an area where the primary engineering control (PEC) is located which provides at least an ISO Class 7 or better air quality and maintains segregation from the adjacent ante-area by means of specific pressure differentials.” Inclusion of the ISO Class 7 or better air quality is a necessary requirement of a buffer area for sterile compounding in USP 797 and is the location of the PEC, even though it is duplicated in the definition of a cleanroom. Also, remove “physically” because “located” alone confers the same meaning.
1735.1(d)	**Cedars-Sinai** Katherine Palmer Rita Shane	The "buffer area" and "cleanroom" definitions overlap by including in the "buffer area" specification that pressure differentials must be measured. However, the requirements of the pressure (minimum differential positive pressure 0.02-0.05- inch water column) are not mentioned until (f) in the "cleanroom" definition section. Additionally, it is unclear in the "buffer area" definition that pressure differentials must be measured, as well as the principle of airflow displacement must be employed. These are two different methods of measuring positive pressure. Displacement airflow may be used if pressure differentials are not feasible (in the case of when physical walls are not separating the buffer and ante areas- USP 797- page 12). In the absence of a physically separated buffer and ante area for medication preparation, USP 797 allows the use of displacement airflow (USP 797- page 12). Application of this to hazardous drug areas is essential for organizations that don't have a separate room to allow for hazardous medication preparation for cancer patients. In the Board Response to comments, the terms high-risk and hazardous are used interchangeably (Attachment 2- third response to comment on 1735.1 (f)).

Code Section	Commenter	Comment
1735.1(d)	**Kaweah Delta Medical Center** Rheta Sandoval	Revise the word “fron” to “from”. Typo.
1735.1(d)	**Kaweah Delta Medical Center** Rheta Sandoval	Respectfully restating concerns communicated in public comment submitted for the 1st 15 day modified text in addition to clarifying information provided in italics below. Concerned about the language “for hazardous compounds, or for chemotherapy compounds”. To not permit the displacement concept to maintain clean room area requirements will have significant impact for some facilities in terms of remodeling and construction costs. Outside of the costs and time necessary to complete facility modifications to meet this requirement, there could be negative impacts if a pharmacy could not continue to provide the potentially life-saving “hazardous” medications needed as a facility works towards gaining compliance with the requirement. Some geographic areas of the State may not have a nearby health facility to provide this type of service or the ability to handle the order volume currently managed by the Pharmacy. Understanding a key element of proposed USP <800> is to require that hazardous drugs be stored in a negative or normal/pressure, and compounding must be completed in certified biological safety cabinets or compounding aseptic containment isolators in a separate room with negative pressure, attempts to harmonize State with Federal Standards may be indicated. However, if the BOP adopts the modified text as proposed and there are not reasonable timelines and expectations for compliance established, it could severely limit patient access to needed care or place tremendous burdens on patients and those supporting their care to travel to a facility that is compliant with the regulation. Please consider the following clarifying information: the verbiage in USP 797 specific to “displacement concept” reads, “The displacement concept shall not be used for **high-risk** compounding.” The reference cited “ISO 14644-4:2001 Cleanrooms and associated controlled environments-Design, construction, and start-up” includes section A.5.2 which describes the displacement concept. The displacement concept is described in this reference as a means to effectively separate clean and less clean adjacent zones without any mention of hazardous compounds or chemotherapy. As such, the term “**high-risk**” should be taken to mean high risk of microbial contamination as described in USP <797>. Currently meet the “low volume” exemption described in USP <797>, hazardous CSP prepared in an ISO 5 CACI using closed-system transfer devices. The PEC (CACI) is located in the ISO 7 buffer area (located in a non-negative pressure clean room). The buffer area is not physically separated from the ante-area, the principle of displacement airflow is employed. Please delete the language “for hazardous compounds, or for chemotherapy compounds” and consider reintroducing at a later time after fully assessing impacts to Pharmacies holding Sterile Compounding Licenses in this state and establishing reasonable timelines for gaining compliance.

Code Section	Commenter	Comment
1735.1(d)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	The previous definition of buffer area was in alignment with USP Chapter 797. The new definition is not in alignment with USP Chapter 797 and imposes significant and very expensive new requirements. The new definition means that neither a CACI nor a BSC can be used to prepare chemotherapy in a cleanroom configuration that utilizes the airflow displacement method and does not have a door between the buffer area and the ante-area. Recommend maintaining the previous definition for buffer area (or adopting the USP Chapter 797 definition for buffer area, “An area where the primary engineering control is located. Activities that occur in this area include the preparation and staging of components and supplies used when compounding CSPs.”).
1735.1(f)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	The new definition is not in alignment with USP Chapter 797 and imposes significant and very expensive new requirements. The new definition (in conjunction with the new definition of buffer area) means that neither a CACI nor a BSC can be used to prepare chemotherapy in a cleanroom configuration that utilizes the airflow displacement method and does not have a door between the buffer area and the ante-area. Recommend adopting the USP Chapter 797 definition for cleanroom, “A room in which the concentration of airborne particles is controlled to meet a specified airborne particulate cleanliness class. Microorganisms in the environment are monitored so that a microbial level for air, surface, and personnel gear are not exceeded for a specified cleanliness class.”
1735.1(d) & (f)	**University Compounding Pharmacy** Joe Grasela	Definition for "Buffer area" and "Clean room" In USP 797 are used interchangeably (pg 12 of USP 797). It would be best to clarify that a "Buffer area" is a designated area with no separated doors or walls with a line of demarcation from the Ante room while a "Clean room" is a physical room with walls and/or door separation from the Ante room that allows for compounding of Hazardous and High risk preparations. We associate our "clean room/buffer room" with walls and the door as our line of demarcation that allows us to compound "Hazardous" or "High risk" compounds. With this clarification, we would then term our sterile compounding room as a "clean room" as opposed to a "buffer area". When USP 800 is released, your current definition of “clean room” doesn't address the negative pressure room requirements (ie: 0.01-0.03 inches of water column, externally vented, 30 ACPH)
1735.1(e)	**Barcon & Associates** Douglas Barcon	Insert “any” or “an” before intermediate

Code Section	Commenter	Comment
1735.1(f)	**Mercy General Hospital** Jeffrey Nehira	The recommendation of the differential positive pressure of 0.02 to 0.05 inch is not standard practice. Recommend following USP<797> 2014 pg 3, "The pressure between the ISO Class 7 (see Table I) and the general pharmacy area shall not be less than 5 Pa (0.02 inch water column). In facilities where low- and medium-risk level CSPs are prepared, differential airflow shall maintain a minimum velocity of 0.2 meters per second (40 feet per minute) between buffer area and ante- area.
1735.1(f)	**Barcon & Associates** Douglas Barcon	Change to “A minimum differential positive pressure of 0.02-to 0.05-inch water column is required” to “A minimum differential positive pressure of 0.02-to 0.05-inch water column is required to segregate the room from the surrounding unclassified spaces to reduce the risk of contaminants being blown, dragged, or otherwise introduced into the filtered unidirectional airflow environment.”
17351.1(g)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	The proposed language is confusing. It appears to say that the HEPA filter that is cleaning the air entering the isolator from the environment must be able to trap airborne particles of drug being compounded inside the isolator. That’s not helpful, since one would want assurance that HEPA filters would trap airborne drug particles exiting the CAI. Recommend that this wording be used instead, “Air exchange with the buffer area should not occur unless the air has first passed through a microbial retentive filter (HEPA minimum) system capable of containing airborne concentrations of the physical size and state of the drug being compounded.”
1735.1(g)	**Barcon & Associates** Douglas Barcon	Change to “Compounding Aseptic Isolator (CAI)” means a form of isolator specifically designed for compounding non-hazardous pharmaceutical ingredients or preparations.” A negative pressure CACI should be used to compound hazardous pharmaceutical ingredients or preparations. A CAI should not be used to compound antineoplastic hazardous drugs per draft USP 800 revision Fall 2014.
1735.1(j)	**Barcon & Associates** Douglas Barcon	Cannot have two definitions for “controlled freezer temperature.” Use of “or” creates two definitions. Note that there is no definition of “controlled freezer temperature” in USP General Chapter 659 Packaging and Storage Requirements, USP 797, or the general notices in USP-37 NF-32. Should either delete “or at a range otherwise specified by the pharmaceutical manufacturer” or delete the word “controlled” from definition and leave remainder of text intact to be consistent with USP 797 rather than potentially risk storage of pharmaceuticals at wrong temperature. There is some concern that products that specify a temperature range colder than -25 degrees C on the lower end of the range, such as a vaccine at -40 degrees C, could be stored in the same freezer with products that specify -20 degrees C at the low end of the range, and this could jeopardize stability of the product or container with the storage limitation of -20 degrees C if stored colder than -20 degrees C.

Code Section	Commenter	Comment
1735.1(l)	**Barcon & Associates** Douglas Barcon	This definition precludes a pharmacy from compounding a sterile preparation, such as premixed large volume intravenous solutions and for example, a 1 gram cefazolin or ceftriaxone antibiotic IVPB, if a manufacturer provides these as frozen IVPB products or inactivated IVPB form. Proprietary bag-vial systems such as ADD-Vantage, Mini-Bag Plus, and others require physical attachment to the infusion bag and should not be considered a commercially available compounded product in the regulation, or many compounded antibiotic IVPBs would be considered a copy. Also need to comply with the Drug Quality and Security Act regarding sterile preparations demonstrably difficult to compound. Suggest changing to: “Copy or essentially a copy” of a commercially available drug product includes all preparations that are comparable in active ingredients and dosage form to commercially available drug products, except premixed large volume intravenous solutions that are not demonstrably difficult to compound; premixed, inactivated, or frozen small volume parenteral products; or proprietary bag-vial systems such as ADD-Vantage, AddEASE, Mini-Bag Plus, and others; and does not include any preparations in which there has been a change, made for an identified individual patient, which produces for that patient a significant difference, as determined by a prescribing practitioner, between that compounded preparation and the comparable commercially available drug product.
1735.1(q)	**Mercy General Hospital** Jeffrey Nehira	Recommend removing"...at a temperature and for a time period conductive to multiplication of microorganisms," since laboratory testing already defines appropriate incubation parameters.
1735.1(r)	**Barcon & Associates** Douglas Barcon	In order to bring in line with the NIOSH List of Anti-Neoplastic and Other Hazardous Drugs document and reinforce and clarify the regulation, suggest changing definition to include hazardous drugs portion too: “Hazardous” means all anti-neoplastic agents and other hazardous drugs as identified by the National Institute for Occupational Safety and Health (NIOSH) as meeting the criteria for a hazardous drug and any other drugs, compounds, or materials identified as hazardous by the pharmacist-in-charge. This change also provides guidance to the PIC in regard to hazardous drugs that are not anti-neoplastic agents.

Code Section	Commenter	Comment
1735.1(t)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	The wording of this definition is confusing and requires clarification. We believe “lot” could be interpreted two different ways. 1. It could be interpreted to include different types of preparations that are prepared during one uninterrupted continuous cycle of compounding. A typical example of this interpretation in a hospital pharmacy: compounding four doses of azithromycin 500 mg/250mL dextrose 5% for four different patients, and two doses of famotidine 40 mg in 250mL dextrose 5% 250mL for one patient, and five doses of furosemide 100mg/100mL dextrose 5% for five different patients. All of these would be prepared in an uninterrupted continuous cycle of compounding. If the above example is the intended interpretation, then we recommend this language: “Lot” means one or more different compounded drug preparation(s) prepared during one uninterrupted continuous cycle of compounding from one or more common active ingredient(s).” 2. It could be interpreted to mean a single type of drug preparation compounded during one uninterrupted continuous cycle of compounding from one or more common active ingredient(s). Using the example above, four doses of azithromycin 500 mg/250mL dextrose 5% for four different patients would be considered one lot. If interpretation #2 is correct, then we recommend this language: “Lot” means a single type of drug preparation(s) prepared during one uninterrupted continuous cycle of compounding from one or more common active ingredient(s).” These comments are being resubmitted because the Board’s response stated the example interpretations provided above were incorrect, but did not clarify the current language, which is ambiguous and unclear.

Code Section	Commenter	Comment
1735.1(t)	**Contra Costa Regional Medical Center and Clinics Inpatient Pharmacy** Cindy Easton	The proposed modified text of this compounding definition simply replaces the word “batch” with the word “lot”. This term still does not differentiate or qualify the difference between making a multiple dose “batch” or “lot” from the process of preparation of several single doses of the same strength, individually, one by one, right after another. Example: If one were to reconstitute a 5 gm bulk package of Vancomycin for injection with 100 ml of Sterile water yielding a concentration of 1 gm/20ml. If the user were then to inject the entire 100 ml of reconstituted vancomycin into exactly 900 ml of sterile D5W giving a concentration of 50 mg/100 ml. If, then – one were to subsequently divide that 1000 ml into 4 doses of 1.25 gm vancomycin in 250 ml for IV infusion – THIS WOULD CONSTITUTE A “BATCH” COMPOUNDED PREPARATION requiring regulated documentation. In this case, the word “lot” could be substituted for the word “batch”. However, suppose a compounder is given 4 labels for Vancomycin 500 mg in 100 ml of D5W. Subsequently they pull 4 vials of vancomycin inj 500 mg powder for reconstitution and 4 single bags of sterile D5W for injection, as well as sterile water for injection. Each vial of 500 mg vancomycin is reconstituted with 10 ml of sterile water in an aseptic environment. The compounder then individually draws up each dose of 500 mg vancomycin and injects in into one of the 4 bags of D5W. The compounder then labels each bag with a patient specific label, including storage and a BUD corresponding to that of USP 797 for the appropriate risk level according to the expected storage. Except for rare cases during shortage or disaster, no more than 24 hours worth of patient specific CSP’s are prepared in this manner. The proposed language does not qualify the difference between patient specific, individually prepared CSP’s and large quantities of CSP’s which may be stored and labeled for a patient on a future date.
1735.1(t)	**Cedars-Sinai** Katherine Palmer Rita Shane	Based on the Board Response (Attachment 2- second response to comment on 1735.1 (t)) the proposed definition of lot was changed to be consistent with 1735.1 (v). Alternatively, recommend changing definition of lot to "greater than one dose" in order to ensure timely preparation of compounded drugs to treat hospitalized patients' conditions. When medications are prepared as single doses, time is of the essence and documentation requirements for a lot would delay patient.

Code Section	Commenter	Comment
1735.1(t)	**Contra Costa Regional Medical Center and Clinics Inpatient Pharmacy** Cindy Easton	One possible example of a resolution for this language might be taken from the: TASK FORCE ON COMPOUNDING OF STERILE PREPARATIONS 2013 Texas State Board of Pharmacy Definitions: (7) Batch--A specific quantity of a drug or other material that is intended to have uniform character and quality, within specified limits, and is produced during a single preparation cycle. (8) Batch preparation compounding--Compounding of multiple sterile preparation units, in a single discrete process, by the same individual(s), carried out during one limited time period. Batch preparation/compounding does not include the preparation of multiple sterile preparation units pursuant to patient specific medication orders. This language better differentiates and qualifies the process of batch compounding by adding the second definition (8) In these 2 definitions the word “lot” could be substituted for the word “batch” in #7 and #8 could be re-written as “compounding a “lot” of multiple doses from single source at a single sitting or staging” In addition, the recommendation language provide by the California Hospital Pharmacist’s Association for the definition of ‘batch” is also helpful: Recommend modifying definition to: “batch means compounding, at any risk level, of two or more finished drug preparation units produced during the same continuous cycle of compounding and prepared in advance for patients yet to be identified” In the above case, the word “lot” can be adequately substituted for the word “batch”. Although it still leaves the actual process unqualified. Layman’s Example If you were to make one cookie from exactly the amount of ingredients required to make that one cookie and give it to one particular person who ordered that particular cookie, it would NOT constitute a batch even if you made 3 cookies for 3 people by weighing out separately the individual ingredients for each cookie and preparing each individually. Even if you cooked all 3 of them at the same time. However, if you dump a bunch of flour, butter, eggs, sugar and nuts in a bowl; mix it up and divide it into a number of similarly sized cookies – THIS CONSTITES A BATCH - MANY CREATED FROM THE COMBINATION AND DIVISION OF ONE. I wish to add that I intended to explain that the suggested substitution of the word "lot" for the word " batch" is still ineffective as the "lot" or "batch" is part of a process which is not qualified or defined in the regulation. This PROCESS would be "batch preparation compounding" or the "compounding of a particular lot of a preparation". The result of this PROCESS is the "batch" or "lot" which consists of the multiple pieces of a divided whole. Those pieces are individual units intended to be alike in size, composition, stability and sterility. In the case of a "batch" or a "lot" produced by "batch preparation compounding", the resulting units are not prepared for specific doses intended for orders for specific patients to be given at a specific date and time.

Code Section	Commenter	Comment
1735.1(y)	**California Hospital Association** BJ Bartleson	First, with the definition as stated, the potency definition will be impossible to meet. For example: A typically compounded product is Vancomycin 1 gram injected into a 250ml bag of normal saline. The 250ml bag is a commercially available product purchased from manufacturers like Baxter or Hospira. Both manufacturers add as much as 25ml of overfill to their bags, which would result in a volume of 275ml. The 1 gram Vancomycin vial from the manufacturer is reconstituted with 20ml of sterile water and added to the 275ml bag of saline, equaling a final volume of 295ml, resulting in a final concentration of 3.39 mg/ml (1000mg/295ml). The labeled potency of the1g/250ml piggyback back would result in a discrepancy of 15% - well above the allowed +/-10%. These are simple compounds from standard manufacturer ingredients and will result in a continuous state of non-compliance with the potency range as defined in the proposed regulations. Second, with a majority of hospitals unable to meet the definition, hospitals will face the need to submit variances to the Board, which would produce the ongoing need for program flexibility that will ultimately tax Board and hospital resources , decreasing both Board and hospital efficiency and effectiveness. Third, CHA submitted comments of concern on the potency issue, both in the October 10, 2014, response letter and in the February 12, 2015, response letter. Several CHA pharmacists testified at the January 28, 2015, hearing where it was agree upon between the Board and testifiers that verbal changes would be accepted if given again in writing during the second comment period. That language was given during the second comment period. However, the proposed changes were rejected as the Board did not have provisional changes in the first round and therefore would not be open for comment in the second round. Therefore, CHA respectfully asks for reconsideration of section 1735.1(y) in the interest of due process and more efficient operations for both the Board and hospitals. We request this language be changed to read: 1735.1 (y) Compounding Definitions. Rewrite section (y) saying, ""Potency" means active ingredient strength within +/- 10% of the labeled amount except when limited to sterile commercial products when the strength must be calculated as the result of a master formula. Sterile commercial products are already at +/- 10% so unable to meet this requirement for compounded products
1735.1(y)	**Mercy General Hospital** Jeffrey Nehira	Suggest adding an appendix of USP34-NG32, 3 Revision referencing "Potency" to the policy for easier referencing of USP version required in CA Pharmacy Law. This has changed since the last draft and should be reviewed through the BOP for adoption when changes are made.

Code Section	Commenter	Comment
1735.1(y)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: USP 797 only describes potency in terms of ensuring potency by monitoring controlled storage areas. In addition, considering the many drugs that could be compounded (biosimilars, immune mediators, blood derivatives, etc) it may be too arbitrary to put such a hard limit on this definition. Solution: Remove section that defines “potency” altogether.
1735.1(ab)	**Mercy General Hospital** Jeffrey Nehira	Under PEC I would remove the wording "…through the use of unidirection HEPA filtered first air." from the definition as it also is not in USP 797. Although it is implied that through the PEC directional flow would be one way, most negative pressure glove boxes can be configured for both positive and negative pressure.
1735.1(ac)	**Mercy General Hospital** Jeffrey Nehira	In the definition of process validation, the second sentence needs more clarification, "If any aspect of the process is changed, the process would need to revalidated." This is required by pharmaceutical manufacturing and is not necessarily practical for hospital practice.
1735.1(ae)	**Mercy General Hospital** Jeffrey Nehira	Listing "inactive ingredients" in this definition implies that all inactive ingredients should be present on the log of all compounded prescriptions as a quality measure, including those used in hospital practice. Clarification is needed regarding the requirement to list inactive ingredients on a hospital compounding log or creating exemptions for acute care settings. Inactive ingredients can be traced back through lot numbers and NDCs of primary medications.
1735.1(af)	**Mercy General Hospital** Jeffrey Nehira	The third and fourth sentences in the definition of Segregated Compounding Area is not in the definition within USP797 and would recommend removal. This also brings into questions definitions of "high traffic flow", what is considered "adjacent to a construction site", etc. For older facilities/hospitals that are constantly renovating, the definition of what is considered a construction site or area can be anywhere in the facility
1735.1(af)	**Cedars-Sinai** Katherine Palmer Rita Shane	It is unclear as to why hazardous sterile-to-sterile medications cannot be compounded in a segregated room as long as the dating requirements are met as described in 1751.8(e) p. 40. In the Board Response to comments (Attachment 2, second response to 1735.1(af)) it indicates that a CACI is required for hazardous compounding in segregated compounding areas. USP 800 does not require a CACI provided that a containment segregated compounding area is limited for use with a BSC when preparing low-or-medium-risk level CSPs with 12-hour or less beyond use dates.

Code Section	Commenter	Comment
1735.1(af)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Recommend allowing compounding of hazardous drugs in a segregated compounding area within a CACI by removing the language “non-hazardous” from “The segregated sterile compounding area shall be restricted to preparing non-hazardous sterile to sterile compounded preparations.” Rationale: USP 797 definition of a Segregated compounding area is “a designated space, either a demarcated area or room, that is restricted to preparing low-risk level CSPs with 12 hour or less BUD”. USP 797 section Placement of Primary Engineering Controls allows placement of a CACI (used for hazardous drug compounding) in less clean than ISO Class 7 areas if the following conditions are met: -The isolator shall provide isolation from the room and maintain ISO Class 5 during the dynamic operating conditions, including transferring ingredients, components, and devices into and out of the isolator and during preparation of CSPs -Particle counts sampled approximately 6 to 12 inches upstream of the critical exposure site shall maintain ISO Class 5 levels during compounding operations -Not more than 3520 particles per m3 shall be counted during material transfer, with the particle count probe located as near to the transfer door as possible without obstructing the transfer. These comments are being resubmitted because the Board’s response was confusing and unclear. The response was, “Reject: Hazardous compounding should not be conducted in a segregated compounding area. Needs a CACI.” The recommendation provided above specifically states that a CACI would be utilized.
1735.1(af)	**Kaweah Delta Medical Center** Rheta Sandoval	Delete the second instance of the word “the” for clarity.

Code Section	Commenter	Comment
1735.1(af)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: Many hospitals have established pharmacy satellites nearby patient care areas to serve our most vulnerable patients (e.g. Intensive Care Units). The central pharmacy is too far from these patient care areas and the pharmacy satellites provide a venue to provide patient care that is closer to the patients. These pharmacy satellites are one room that provides a place for the pharmacy to perform order verification, drug storage, and drug preparation. Many of the pharmacy satellites have very limited room, thus the pharmacy will place compounding aseptic containment isolators (CACIs) which are enclosed to the surrounding environment and should have evidence from the manufacturer that they meet USP chapter 797 and Controlled Environment Testing Association (CETA) requirements. If one were to believe that this is an unverified study then one would have to question most of the conclusions derived from USP 797 as many of the conclusions taken from there are not based on "randomized controlled trials". We believe that we can remove the 3 foot no sink/drain requirement when CACIs are used to support pharmacy satellites. The alternative would be to close these pharmacy satellites that do not have the room to abide by the 3 foot no sink/drain rule which is not consistent with a patient centered care model. Solution: Make an exception that if the ISO Class 5 PEC is a CACI, that the three foot sink/drain rule does not apply while maintaining that sinks and drains should not be placed in a buffer area or in ISO class 7 or better.
1735.2(c)(1)	**Senator Jeff Stone**	There is also a provision in the proposed regulation that would require the prescriber to list the number of patients for whom the ordered drug is needed or anticipated and the quantity for use in each patient. This seems very intrusive from a pharmacy relations perspective and has undertones of distrust towards prescribers and their judgment in ordering for their office. No other provider or vendor would ever be required to ask such a prying question of a licensed physician. This will surely lead to immediate negative feedback and animosity from prescribers. Pharmacists have worked long and hard to develop the trust and respect in our relationships with prescribers as our colleagues.
1735.2(c)(1) Incorrectly Listed as 1753.2(c)(1)	**Mercy General Hospital** Jeffrey Nehira	The new requirement to have the prescriber list the number of patients seen in the office and have pharmacies calculate a 72 hour supply is impractical and would require a scope of record keeping difficult to enforce. The prescriber can list any number of patients on the prescription, and the pharmacy would have to dispense any amount required for the 72 hour supply. The previous definition that the prescriber could only provide up to a 72 hour supply for the patient is more practical.

Code Section	Commenter	Comment
1735.2(c)(1)	**People's Pharmacy** Rashmi Mediratta	1. How are we to determine a price that fairly reflects the fair market value. In my opinion, this is a business decision and not a regulatory decision. Pricing is based on the costs involved to operate a business. 2. Re: the prescribers providing the pharmacy with the list of number of patients upon or before receiving an order for Compounded office supply; my comment/suggestion is to have the prescriber send the list of the patients that have received the compounded formulations on a weekly or bi weekly basis to the pharmacy. The list should include the name of the patient, address, name of the medication and the LOT#. Let us make regulations that the prescribers will see as beneficial to their patient base, rather than added paperwork. 3. What is the interpretation of the word “furnishing”?
1735.2(c)(2) Incorrectly Listed as 1753.2(c)(2)	**Mercy General Hospital** Jeffrey Nehira	To deliver to the prescriber's office puts excessive burden on the distributing pharmacy and is very inefficient operationally. Prescriber's often order medications for office use, and pick them up from the pharmacy.
1735.2(c)(3)	**People's Pharmacy** Rashmi Mediratta	1. This regulation is applicable to some extent on non-sterile preparations where capsules, tablets, oral suspensions can be dispensed by the prescribers to their patients in limited quantities without compromising the medication itself. However, in case of sterile preparations, for dispensing to Veterinary patients in particular by their Veterinarians, the limited days’ supply rule might in fact harm the patients, as the Veterinary clinics and staff are not trained and skilled to be performing sterile manipulations on prepackaged sterile preparations. Trying to make 72 hours or 120 hours aliquots of sterile preparations for veterinary patient is in fact going to put our veterinary patients at higher risk of contracting infections. 2. In regards to a Compounding Pharmacy compounding and dispensing a patient specific sterile compounded prescription, patients might have to wait for a minimum of 14 days for the medication, due to testing requirements. Having access to their medications, compounded and tested by a licensed Compounding Pharmacy and dispensed by their prescriber is definitely more beneficial for patient care, by not interrupting the therapy and as such encouraging compliance by not inconveniencing them. 3. In regards to Compounding Pharmacies compounding very small amounts of Sterile Preparations, for office supply to meet the 72 hour regulation, will not be cost effective for the patient, as the primary cost of Compounded Sterile Preparations do not lie in the ingredients but on the time, equipment, testing etc. Suggestion: In the case of self-administered ophthalmic drops, allow the prescriber to dispense a quantity sufficient for 30 days, as stated under 1735.1 (n) Compounding Definitions. This will ensure continuity of the therapy and compliance.

Code Section	Commenter	Comment
1735.2(d)(2) Incorrectly Listed as 1753.2(d)(2)	**Mercy General Hospital** Jeffrey Nehira	An exemption should be made for sanctioned drug studies. Although medications can be removed from the market for one indication, they should be able to get re-introduced and compounded if they are a study drug (this commonly occurs for medications that have a NDA for a separate indication.)
1735.2(d)(3) Incorrectly Listed as 1753.2(d)(3)	**Mercy General Hospital** Jeffrey Nehira	Preparing CSPs in a hospital setting to be medically necessary is sometimes required even though products are commercially available, especially in DSH hospitals or in rural areas where medications may be immediately necessary and not available for delivery for an extended period oftime. I believe an exemption should be written for urgent/emergent care or when medically necessary. With the amount of shortages that are occuring in todays environment, maintaining documentation of drug shortages that are in the high hundreds to thousands provides an undo burden on pharmacies; particularly in acute care settings.
1735.2(d)(3)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: Many medications that are in short supply in "real time" may not be on the ASHP or FDA drug shortage list in a timely manner (e.g. most recent example IV Protonix January 2015). ASHP and FDA recognize that this may happen as they have to rely on clear communications to them for their source of information. Solution: Add "Manufacturer, Wholesaler, and/or Distributor acknowledge and provide documentation that the drug is in short supply."
1735.2(e)(5) Incorrectly Listed as 1753.2(e)(5)	**Mercy General Hospital** Jeffrey Nehira	Clarification or an example regarding "specific compounding steps" is necessary to prevent confusion on what information is necessary.
1735.2(e)(5)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: The language may be too broad. We understand it would be hard to place exactly what is required considering all of the entities that will be using these regulations, but perhaps we can narrow the language by inserting phrases such as "essential compounding steps". This will help facilitate pharmacies to receive approval during the policy approving process who are based in institutions with multidisciplinary committees by leaving out unwanted minutia of the compounding process in policies and procedures. Solution: Reword section to state "Specific and essential compounding steps used to prepare the drug"

Code Section	Commenter	Comment
1735.2(j-k)	**St. Rose Hospital** Joy Lai	Why are all reference to self assessment removed? The section is to address self assessment so please add reference to the Compounding Self Assessment that needs to be done every odd numbered year: The California Code of Regulations section 1735.2 requires the pharmacist-in-charge of each pharmacy licensed under section 4037 or 4029 of the Business and Professions Code that compounds drug products to complete a self-assessment of the pharmacy's compliance with federal and state pharmacy law. The assessment shall be performed before July 1 of every odd-numbered year. The pharmacist-in-charge must also complete a self-assessment within 30 days whenever; (1) a new pharmacy permit has been issued, or (2) there is a change in the pharmacist-in-charge; or (3) there is a change in the licensed location of the pharmacy. The primary purpose of the self-assessment is to promote compliance through self-examination and education.
1735.3(c)	**Barcon & Associates** Douglas Barcon	The comma before "and" appears to be deleted unintentionally. It needs to be restored.
1735.4(c)	**Mercy General Hospital** Jeffrey Nehira	With regard to drug labeling I believe this regulation requiring both the names of the compounding pharmacy and dispensing pharmacy, if different, should also state, "if not apparent from the container". Products may come from multiple sources and this requirement currently states that the pharmacy label should have both names. This is impracticle if the original pharmacy label is apparent from the prescription and has the information required. (ex. TPN formulations)
1735.5(c)(2)	**Mercy General Hospital** Jeffrey Nehira	This statement conflicts with 1735.3(6). Recommend exempting compounds already dispensed and administered for one time administration.
1735.5(c)(4)	**Mercy General Hospital** Jeffrey Nehira	Reference to "disinfecting the facility (physical plant) used for compounding" needs clarification. Regulations already exist for the requirements of cleaning walls, ceilings, etc. The reference to "the facility (physical plant)" is not defined in the definitions at the beginning of the document.
1735.5(c)(7-8)	**Mercy General Hospital** Jeffrey Nehira	Recommend removal of the requirement for annual review. Although this is in current policy, this differs from other regulatory body requirements for hospitals. Request review, "at least every 3 years" or to similar verbiage in Title 22. Reference to "signed and dated by the pharmacist-in-charge" should be updated to include electronic signatures.
1735.5(c)(7-8)	**St. Rose Hospital** Joy Lai	Policies and procedures manual will be kept online with dates of review (using PolicyStat). The review of the policies and procedures will be performed by P&T. Is having a signature on a paper policy still required if digital originals are kept on a secured server?

Code Section	Commenter	Comment
1735.5(c)(9)	**Mercy General Hospital** Jeffrey Nehira	Need further clarification regarding room temperature storage. Currently regulations state that medications are stored at controlled room temperature but there is no requirement for daily monitoring. Request an extended implementation date if this is now required for hospital settings.
1735.5(c)(10)	**Mercy General Hospital** Jeffrey Nehira	Suggest and exemption for health care settings with a facility services policy regarding appropriate function of refrigeration devices.
1735.7	**Mercy General Hospital** Jeffrey Nehira	Need further clarification regarding the record keeping requirement "demonstrating that all staff have been trained on all policies and procedures...." Time frame for the record keeping requirement should be specified and further clarification should be included specifying the training of pharmacy staff, as this is a BOP requirement. Pharmacies do not have oversight of providers under the medical board.
1735.8(c)	**St. Rose Hospital** Joy Lai	Does this mean a schedule must be made for ALL compounded drug preparations made in the pharmacy and that ALL compounded drug preparations must be tested for integrity, potency, quality, etc on an annual basis? Or can a random sampling of different compounded drug preparations be used for routine testing?
1735.8(c)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Recommendation: Add language between the first and second sentences of 1735.8 (c) to clarify the exact requirements related to the quality assurance plan: "The criteria by which preparations would be tested for potency, quantitative analysis, and labeled strength analysis shall be described in the quality assurance plan. Rationale: This language could be interpreted to require that quantitative and qualitative analysis be performed on all compounded products regardless of cost, availability of the actual assay, or scientific validity. It has been our experience that some Board of Pharmacy inspectors have interpreted this language to require end product potency testing during of all pharmacy-compounded products. KP and many pharmacy professionals disagree with those requirements as they are inconsistent with the intent and provisions of the regulation 1735, et. seq. Pharmacies are compliant with 1735.8(c) if they have a PLAN that includes the elements mentioned above. Quantitative and qualitative laboratory type testing is not required unless specified for each product in our policies and procedures generally or by category - or in the Master Formula for a particular product. Test records of tests only have to be retained if such test was done either as a matter of policy or pursuant to an investigation after the raising of a quality concern for particular compounded preparation or a batch of a compounded preparation. Please see the detailed testimony from KP regarding this issue which was presented to the BOP Enforcement and Compounding Committee on September 16, 2014: These comments are being resubmitted because the Board's response of Jan.

Code Section	Commenter	Comment
1735.8(e)	**Mercy General Hospital** Jeffrey Nehira	Suggest and exemption for health care settings with a facility services policy regarding appropriate function of refrigeration devices.
1735.8(e)	**Barcon & Associates** Douglas Barcon	Change “or” to “and”, so the QA plan includes responding to out-of-range temperatures in the pharmacy and patient care areas versus one or the other.
1751(b)	**Mercy General Hospital** Jeffrey Nehira	This requirement for venting may provide a challenge for DSH and rural hosptials. Request exemption for these settings. Referencing this code of regulations as an appendix in the CA law book would be helpful as the referenced chapter may change,
1751(b)(1)	**Senator Jeff Stone**	The proposed regulations also recommend recertification of each ISO environment every 6 months versus the current annual certification. It seems to make more sense to have this recertification done on an annual basis except for new cleanrooms and any cleanroom that fails an annual recertification. In the event that a facility fails its annual certification, it should be required to rectify and be subject to certification every 6 months until 3 consecutive successful certifications occur. Further, it seems to make more sense to have viable surface sampling be subject to annual testing rather than quarterly.
1751(b)(1)	**St. Rose Hospital** Joy Lai	How long should certification records be retained in the pharmacy? Suggestion for 3 years was made but then crossed out. There should be a cross reference 1751.4 subdivision (f) if applicable.
1751(b)(3)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: Many hospitals have established pharmacy satellites nearby patient care areas to serve our most vulnerable patients (e.g. Intensive Care Units). The central pharmacy is too far from these patient care areas and the pharmacy satellites provide a venue to provide patient care that is closer to the patients. These pharmacy satellites are one room that provides a place for the pharmacy to perform order verification, drug storage, and drug preparation. Many of the pharmacy satellites have very limited room, thus the pharmacy will place compounding aseptic containment isolators (CACIs) which are enclosed to the surrounding environment and should have evidence from the manufacturer that they meet USP chapter 797 and Controlled Environment Testing Association (CETA) requirements. If one were to believe that this is an unverified study then one would have to question most of the conclusions derived from USP 797 as many of the conclusions taken from there are not based on “randomized controlled trials”. We believe that we can remove the 3 foot no sink/drain requirement when CACIs are used to support pharmacy satellites. The alternative would be to close these pharmacy satellites that do not have the room to abide by the 3 foot no sink/drain rule which is not consistent with a patient centered care model. Solution: Make an exception that if the ISO Class 5 PEC is a CACI, that the three foot sink/drain rule does not apply while maintaining that sinks and drains should not be placed in a buffer area or in ISO class 7 or better.

Code Section	Commenter	Comment
1751.1(a)(5)	**Mercy General Hospital** Jeffrey Nehira	See comment for: 1735.5 (c)9 above.
1751.1(a)(5)(c)	**Barcon & Associates** Douglas Barcon	Controlled freezer temperature.
1751.1(a)(7)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: USP 797 allows for at least daily documentation or by using a continuous recording device. We would like to continue to allow the use of a continuous recording device as an alternative which would also give the facility better “real time” data. Solution: Reword the section to state “Documents indicating daily recordation or by continuous recording device of air pressure differentials…”
1751.4(d)	**Clinical IQ, LLC** Eric Kastango	The cleaning section of the chapter is poorly written and misleading. It is important to differentiate between cleaning and disinfecting. Cleaning needs to be done with a germicidal detergent and water which was not explicitly detailed in USP 797. I am expecting it will be corrected in the next revision. Cleaning is only done once a day (unless needed for a spill), and the disinfecting with sterile IPA or another suitable sterile disinfectant would be used according to the schedule detailed below. I am suggesting the following modification. Proposed Title 11 CCR Section 1751.4(d) All ISO Class 5 surfaces, work tables, carts, and the floor in the buffer area will be cleaned at least daily (at the beginning or end of the compounding day or shift) using a germicidal detergent and water. Surfaces in the ISO Class 5 PEC shall be disinfected using a suitable sterile agent (e.g. sterile IPA) frequently, including (1) at the beginning of each shift (2) before and after each lot (3) after each spill; and (4) when surface contamination is known or suspected I appreciate your consideration of this proposed language.

Code Section	Commenter	Comment
1751.4(d)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: The most recent USP 797 regulations state that cleaning of the ISO 5 PEC should occur at the beginning of each work shift, before each batch (USP 797 only uses the word batch in referencing high-risk compounding) preparation is started, every 30 minutes during continuous compounding periods of individual CSPs, when there are spills, and when surface contamination is known or suspected from procedural breaches. With the new proposed definition of "lot," interruption of workflow of hospital compounding in order to clean before and after each lot may impact the timeliness of medication delivery to patient and could introduce potential for medication errors. Solution: Remove "before and after each lot" and replace with "every 30 minutes during continuous compounding."
1751.4(d)	**Kaiser Permanente** Steven Gray Doug O'Brien Don Kaplan	Consider a typical scenario in a clean room in a hospital pharmacy. During a 15-minute period of compounding operations, pharmacy personnel could compound four doses of azithromycin 500 mg/250mL dextrose 5% for four different patients, two doses of famotidine 40 mg in 250mL dextrose 5% 250mL for one patient, and five doses of furosemide 100mg/100mL dextrose 5% for five different patients. Under the definition of "lot", pharmacy personnel would be required to clean and disinfect the ISO Class 5 PEC before and after each lot – four times in 15 minutes. If one considers the number of lots that would be compounded in four hours, the PECs would need to be cleaned and disinfected 50 to 60 times. We therefore recommend that 1751.4(d)(2) be deleted. Subsections 1751.4(d)(1) , 1751.4(d)(3) , and 1751.4(d)(4) are sufficient. These comments are being resubmitted because the Board's response was ambiguous and unclear. The response stated, "Language changed and Batch definition changed." In fact, the language did not change (with the exception of the substitution of the word "Lot" for the word "Batch) and as mentioned earlier in this document in the comments regarding 1375.1(t), the current definition of the word "Lot" is ambiguous and unclear.

Code Section	Commenter	Comment
1751.4(d)(2)	**Kaweah Delta Medical Center** Rheta Sandoval	Respectfully restating concerns communicated in public comment submitted for the 1st 15 day modified text in addition to clarifying information provided in italics below. Cleaning and disinfecting surfaces of the ISO Class 5 PEC before and each lot (per the proposed definition in 1735(t)) may not be feasible depending on the scale of operations. There could be interference with timely medication preparation and dispensing and significant operational impacts. For pharmacies that are preparing upwards of 60,000 dosage units annually, 5 minutes or more spent cleaning and disinfecting surfaces in the ISO 5 PEC before and after compounding each "lot" would have a definite impact on operations and costs. USP and ASHP Guidelines on Compounding Sterile Preparations requires cleaning and disinfecting before each batch, with a "batch" defined differently then the BOPs proposed definition of "lot" resulting in a frequency that is more realistic while maintaining adequate safeguards against microbial contamination. *The USP intent of the cleaning the PEC with a germicidal detergent is that it only needs to be done once a day (end of the compounding day or the beginning) (Personal Communication. Eric S. Kastango, MBA, RPh, FASHP. 3/25/15). The work areas need to be disinfected with sterile IPA or another suitable agent before each batch (Personal Communication. Eric S. Kastango, MBA, RPh, FASHP. 3/25/15). In the Cleaning and Disinfecting the Compounding Area section of USP <797>, it states "When the surface to be disinfected has heavy soiling, a cleaning step is recommended prior to the application of the disinfectant".* Please consider the following options: 1. Deleting 1751.4(d)(2) 2. Revise 1751.4(d)(2) to read: before each lot (disinfection only);

Code Section	Commenter	Comment
1751.4(f)	**Barcon & Associates** Douglas Barcon	Within the same section of USP 797 that includes numbers (1), (2), and (3) criteria, it also states: “It is incumbent on the compounding personnel to obtain documentation from the manufacturer that the CAI/CACI will meet this standard when located in environments where the background particle counts exceed ISO Class 8 (see Table 1) for 0.5-um and larger particles.” While criteria (1), (2), (3) include “shall” as in the source text of USP 797 in the section on placement of primary engineering controls, the intent in USP 797 is to also include manufacturer documentation that the CAI or CACI will meet criteria (1), (2), (3) in conditions worse than an ISO Class 8 ante-area, i.e., uncontrolled air quality or non-ISO classified room. Note that USP 797 makes no reference to placement of a CAI or CACI in an ISO Class 8 compliant area. It must be inferred that CAI or CACI placement in such area would fall under the same category as air quality worse than ISO Class 8 because it exceeds ISO Class 7. Suggest add (4): (4) manufacturer documentation/certification states that the CAI or CACI is compliant with (1), (2), and (3) of this section when located in located in environments where the background particle counts exceed ISO Class 8 for 0.5-um and larger particles or is a non-ISO classified area. The addition of “or is a non-ISO classified area” was made because CAI/CACI manufacturers also test their units for compliance in regular room air, which is not tested for ISO compliance but generally is worse than ISO Class 8. Section 1751.4 (h) addresses placement of a CAI in a non-ISO classified room but seems out of sync with the criteria in section 1751.4 (f) and conflicts with it if not changed.
1751.4(g)	**University Compounding Pharmacy** Joe Grasela	Gloves tested to meet ASTM 6978-05 are standard practice for assessment of resistance of medical gloves to permeation by chemotherapy drugs. Why is it necessary to double glove? USP 800 doesn't require or propose a double glove when working with hazardous compounds.
1751.4(g)	**St. Rose Hospital** Joy Lai	If hazardous sterile compounding is performed in a negative pressure PEC, are the standards of garbing and gowning the same as if compounding is performed in an aseptic containment isolator (ie two layers of gloves required)? For sterile compounding, a non-shedding gown is required so for hazardous drug compounding, a low-shedding gown is acceptable?

Code Section	Commenter	Comment
1751.4(i)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: The most recent USP 797 regulations state that viable surface sampling be done periodically. Many hospitals conduct surface sampling every six months to coincide with the requirements for PEC and cleanroom certification. Pharmacies may also not have access to qualified individuals every quarter for surface sampling, but would have access to these qualified individuals every six months for the PEC and cleanroom certifications. Solution: Reduce the viable surface sampling requirement to every six months to coincide with other sampling that will be performed by qualified outside vendors.
1751.4(j)	**Barcon & Associates** Douglas Barcon	The temperature in this section should pertain to the sterile compounding area only per USP. It should not pertain to the whole pharmacy. Cooling the entire pharmacy to 68 degrees Fahrenheit will generally cause staff not garbed for compounding to feel cold and will cause excessive HVAC energy consumption. This may be good to increase profits for PG&E, Southern California Edison, and Sempra Energy, but is not an efficient use of energy.
1751.4(j)	**Anonymous**	This is regarding 1751.4 (j) The pharmacy shall have a comfortable and well-lighted working environment, which includes a room temperature of 20 degrees Celsius (68 degrees Fahrenheit) or cooler to maintain comfortable conditions for compounding personnel when attired in the required compounding garb. What is a "comfortable condition" is very subjective. What is comfortable for one person may not be comfortable for someone else. Some may find 68F ideal, while some may find it too cold, and yet some may still consider that too hot. Therefore, to mandate 68 or below in a state regulation is unreasonable. When I showed this to my pharmacy tech, she was shocked. She has bad arthritis that acts up when it's too cold, and she usually keeps the thermostat at a comfortable (to her) 70+. Especially since we are talking about California, many Californians will find 68 degrees too cold, especially during winter. Instead of 68 or below, state regulation can specify a range (example, 66 to 72) to accommodate what is comfortable for the majority, or maybe this regulation is not necessary at all. Thank you for considering this suggestion.
1751.7(e)	**Senator Jeff Stone**	The Board is seeking guidelines that are not consistent with the U.S. Pharmacopeia (USP) standard <797>. There is no scientific evidence to support the State Board of Pharmacy in adopting a standard that is STRICTER than those that exist in USP <797>. For example, the USP <797> only requires non-sterile to sterile preparations to be tested for sterility when produced in batches of more than 25 individual doses. The Board of Pharmacy (BOP) is proposing to require non-sterile to sterile preparations to be tested for sterility when produced in batches of 2 or more individual units. The BOP has inappropriately argued that the USP standards are arbitrary and not evidence based, but the USP remains the international authority for setting these standards and the proposed California regulations should thus remain consistent with <797>.

Code Section	Commenter	Comment
1751.7(e)	**Senator Jeff Stone**	The proposed regulations require that all sterile compounded preparations be quarantined while awaiting test results with no authority to release the medication from quarantine in emergency situations. These delays can jeopardize patient access to these critical drugs such as when nationwide drug shortages exist. Patients can be harmed if these compounded medications are not made available. For many existing pharmacies that are licensed to compound sterile products, it is extremely rare or ever, that these sterility tests come back positive because of the rigorous regulations adhered to by pharmacists compounding sterile products and the high competency of pharmacists engaged in sterile compounding in California. Another example: Many facilities use a LET Solution (Lidocaine, Epinephrine, Tetracaine) for pediatric anesthesia. While this should be compounded as a high risk compounded sterile product by a compounding pharmacist, "LET KITS" are now available for purchase from major compounding distributors, and there have been reported instances of physicians perfotming this compounding because the facilities they work with do not have high-risk capabilities and thus don't compound this item internally. This is an example of underground compounding which will be exacerbated if the BOP should adopt these overreaching regulations. I remain concerned that more examples of high risk compounding will be conducted by untrained professionals that are NOT under the jurisdiction of the BOP potentially causing contaminated drug induced sepsis and death of patients. Further, if the BOP adopts the more strict testing protocols, the price of sterile compounds will become much more expensive, and there will be longer delays in dispensing these critical medicines. Hence, there will be increased risks that physicians and health care facilities/clinics will resort to alternative methods for preparing the medications they must have

Code Section	Commenter	Comment
1751.7(e)	**California Pharmacist Association** Brian Warren	Modify Section 1751.7(e) as follows (additions in red, bold, italics): (c) (e) Batch-produced sterile injectable drug products preparations compounded from one or more non-sterile ingredients Non-sterile-to-sterile batch drug preparations that meet the criteria in paragraph (1) or (2) shall be subject to documented end product testing for sterility and pyrogens that are exposed longer than 12 hours at 2 to 8 degrees C and longer than 6 hours at warmer than 8 degrees C before they are sterilized shall meet the sterility test in accordance with methodologies and processes found in Chapter 71 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), and testing for pyrogens in accordance with the methods of Chapters 85 and 151 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference, and shall be quarantined until the end product testing confirms sterility and acceptable levels of pyrogens, per USP chapter 85 limits, before dispensing. This requirement of end product testing confirming sterility and acceptable levels of pyrogens prior to dispensing shall apply regardless of any sterility or pyrogen testing that may have been conducted on any ingredient or combination of ingredients that were previously non-sterile. (1) Non-sterile-to-sterile drug preparations that are prepared in groups of more than 25 identical individual single-dose packages for administration to multiple patients. (2) Non-sterile-to-sterile drug preparations that are exposed longer than 12 hours at 2 degrees Celsius to 8 degrees Celsius or longer than 6 hours at warmer than 8 degrees Celsius before they are sterilized.
1751.7(e)	**Cedars-Sinai** Katherine Palmer Rita Shane	Would recommend including this section back into the regulation revision to avoid patient loss of life or intense suffering due to the inability to provide emergency medications to patients. If other measures have failed, the patient could bleed to death without this provision. Recommendation: In a circumstance where a sterile drug preparation compounded from one or more non-sterile ingredients is necessary for immediate dispensing where failure to dispense could result in loss of life or intense suffering, (1) Prior to dispensing: (A) Notifying the prescriber of the inability to conduct testing; (B) Suggesting an available alternative product to the prescriber; and (C) Securing the prescriber's and patient's written consent to dispense. (2) And subsequent to dispensing: (A)Send random sample for sterility and pyrogen testing as part of process validation (B) Notify physician if results demonstrate microbial growth or pyrogens (C) Have protocol approved by the Pharmacy & Therapeutics Committee

Code Section	Commenter	Comment
1751.7(e)	**Pacific Compounding Pharmacy** Marie Cottman	Comments: With regards to pyrogen testing, this regulation is in conflict with USP <797>, <85> and <771> recommendations for testing ALL sterile products. USP <797> specifically exempts ophthalmic drops and inhalations from testing for pyrogens. Additionally, USP <85> only provides guidance and limits for pyrogens found in injectable products. There is no defined limit of a pyrogen for a sterile ophthalmic drop or for an inhalation. Without a defined industry standard, it is inappropriate to expect that compounders can comply with this regulation as proposed. Recommendation: Clarify that pyrogen testing is for sterile INJECTABLE drugs only. Consider rewording 1751.7 (e): All non-sterile-to-sterile batch drug preparations shall be subject to documented end product testing for sterility ~~and pyrogens~~ and shall be quarantined until the end product testing confirms sterility. Additionally, non-sterile-to-sterile batch injectable drug preparations shall be subject to documented end product testing for pyrogens and shall be quarantined until the end product testing confirms both sterility and acceptable levels of pyrogens, per USP chapter 85 limits, before dispensing. This requirement of end product testing confirming sterility and/or acceptable levels of pyrogens prior to dispensing shall apply regardless of any sterility or pyrogen testing that may have been conducted on any ingredient or combination of ingredients that were previously non-sterile. References: USP <797> High Risk Sterile Compounds Sterility Testing and Bacterial Endotoxin (Pyrogen) Testing. USP <85> Bacterial Endotoxins Testing USP <771> Ophthalmic Preparations- Quality Tests. This document is consistent with <797> and <85> in that on page 8, Sterility is a quality test required for ALL ophthalmic dosage forms, but Bacterial Endotoxins is required only for injected ophthalmic drug products.

Code Section	Commenter	Comment
1751.7(e)	**Harbor Compounding Pharmacy** Mai Tran Sam Kitahara	This verbiage is very confusing. Please clarify. For example: • We have a sterile preparation "Drug A+B" that was compounded from sterile-to-sterile process using Drug A and Drug B. • But both Drug A and Drug B were compounded by the pharmacy from ingredients that was previously non-sterile and were tested/confirmed to pass sterility and pyrogen levels • This verbiage implies that we still need to perform sterility and pyrogen testing for Drug A+B since it came from a source that was previously non-sterile. • Since Drug A and Drug B have confirmed to be sterility and have acceptable levels of pyrogen, shouldn't this be considered LOW RISK sterile compounding? Recommendation: • Please omit this verbiage.
1751.8	**Barcon & Associates** Douglas Barcon	Delete “a more” and replace with “an”
1751.8(a) & (b)	**University Compounding Pharmacy** Joe Grasela	Section (b) is clearly defines the end user and applicable to multiple patients or to one patient using a multi-use container however section (a) does not define it's end user. Is section (a) also applicable to multiple patients or multi-use container as well? Section (b) is only applicable if using more than 3 commercially manufactured packages. Is that the only difference? Therefore why wouldn't section (a) be applicable for multiple users or multi-use container?
1751.8(a) & (b) & (c)	**Barcon & Associates** Douglas Barcon	There is no definition for “controlled freezer temperature” in USP 659, USP 797, or general notices in USP-37 NF-32. USP 797 states: “and for 45 days in solid frozen state between -25 degrees and -10 degrees C.” Inconsistent freezer temperatures throughout the freezer can result in some sterile compounded drug preparations or products (premixed piggybacks) being in semi-solid state even though the reported temperature is within range. The key is solid frozen state to qualify for 45-days BUD. Suggest incorporate USP 797 definition.
1751.8(e)(1)	**St. Rose Hospital** Joy Lai	If sterile compounded drug preparation was hung within 1 hour following start of compounding process, when should it be removed? For example, if a drip was made and hung within 1 hour, should the drip be removed and another drip compounded in its place after a set time even though the first bag has not been emptied?

Code Section	Commenter	Comment
1751.8(e)(1)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: Many large health care facilities already employ the use of an "immediate use only" label for reasons other than a 1 hour BUD (e.g. criticality of the drug, cost of the drug, etc.) In addition, other regulatory agencies (i.e. The Joint Commission) have stipulations in existence for labeling "immediate use" sterile products (i.e. medication name, strength, quantity, diluent and volume, expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours). To avoid confusion, it would be beneficial to specifically remove the requirement of labeling the product for "immediate use only" and impose the existing regulation of the expiration time when expiration occurs in less than 24 hours. Solution: Replace the requirement of labeling for "immediate use only" with the exact one hour beyond use date and time.
1751.8(e)(1)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: This section does not stipulate as to whether this applies to all healthcare professionals who are qualified to engage in immediate use sterile compounding drug preparation outside the profession of pharmacy. Solution: Please clarify and insert verbiage to make clear of whether or not this stipulation applies to all professions outside of pharmacy who are qualified to engage in immediate use sterile compounding (e.g. RN).
1751.8(e)(2)	**Community Regional Medical Center** Bruce Lepley	Reason for Concern: Other regulatory agencies (i.e. The Joint Commission) have stipulations in existence for one to compound immediate use sterile products which include: "…a delay could harm the patient …or the products stability is short. To mitigate risk of confusion we recommend adopting similar language that would accomplish the intent of this section. Solution: Reword section to use "a delay could harm the patient" or "the products stability is short".

Code Section	Commenter	Comment
		Cancer drugs have been associated with multiple drug shortages and adverse patient outcomes.1 One research study determined that substitution with cyclophosphamide for mechlorethamine resulted in significantly less efficacy in treatment of children with Hodgkin's lymphoma.2 Additionally, as a result, counterfeit chemotherapy is an area of national concern, until such time as E-Pedigree is available.
1751.9(b)	**Cedars-Sinai** Katherine Palmer Rita Shane	Closed system transfer devices (CTSD) protect the vial from entry of external bacteria after initial puncture beyond the USP 797 approved 6 hour time limit.3 It has been shown that one of these systems maintains sterility of the vials to which it is attached for up to 168 hours (7 days).4 Recommendation: Allowance to use CTSDs with supporting literature to extend the beyond use date of single dose vials of chemotherapy to 24 hours or use through the end of the shift, whichever is shorter. This recommendation is more conservative than the timeframe of 7 days listed in the CTSD study and would assist institutions in conserving scarce chemotherapy medications.
		The following comments were submitted orally at the regulation hearing on 11/4/2014; however, they were inadvertently excluded from the 45-day comment review and must be reviewed at this time.

Code Section	Commenter	Comment
1735.1	**Lynn Paulsen**	Potency testing +/- 10%. This is a challenge. You start out with a product that is +/- 10% (so the mfg took up the entire slack). She explained how a good syringe is +- 5%. This brings a +- of $15. She said that perfect technique / perfect measurement will be +- 10% and other times it will be greater. The more times you add, you increase the margin of error. Board inspectors are asking for lab testing results. The second reaons is that the other group of drugs we titrate. But this is not true when we are purchasing sterile dugs from a 503b pharmacy purchased from non-sterile sources. They need the drugs to be +/- 10%. As they manipulate, the rate will be greater. They recommend that a calculation be provided for what the range should be so that if someone from the board requested testing they wouldn't have the +/- problem. For the 503b PHYs, they will have the same issue as we would internally. Unlesss the drugs are entirely dumped into the patient or titrated, This has been the practice in HSP pharmacies for at least the last 41 years.
1735.1	**Steve - CSHP**	Recommend that the board address compounding regs by dividing them into those that practice compounding in hospitals, and then those that govern the process outside of hospitals. That would make it easier to understand and better for patients. It would also be easier to enforce. The practice of compounding HSP does not quite fit with the +/- 10%. Because when you buy product that is compounded outside of the HSP it starts with the +/- 10%. There are other products that the FDA allows more than the 10%. 1735.1q applies to all compounding. When you compound a cream or ointment, it is administered on ta patients titration of the need. Thus the amount that is administered (such as a cream) to a patient by different persons. For overall clarity enforcement and proteaction of the patients, they suggest separating the regs to those that apply to HSPs and those which do not.
1751.4	**Doug O'briensat**	Language is not consistent with 1751.8
1751.8	**Doug O'briensat**	If you have a barrier isolator that is certified you can't assign the normal default BUD. Low-volume chemo exemption. Exact volume is not defined. They recommend that the average be increased to 20 doses per week. Reason – small hospital – if you do emergency induction infusion it can be one dose a day for 7 days. If that were the case, the hospital could not dose even one patient. They recommend a increase.

Code Section	Commenter	Comment
No Sections	**Jeffrey - Dignity Health**	Cleaning of the hood. Recommend increasing the volume to 20 per week. Based on how many products are prepared. Compare to manufacturing guidelines. Compounding for investigational drugs, and those that are used for compassionate care. If we are trying to be in the forefront of these drugs, he is concerned and believes there needs to be an exemption for these types of drugs. (make them exempt from the regs). For nuclear pharmacy – make those exempt) For preps done within 24 hours or 72-hour drugs Impracticable. Suggests getting the input of a microbiologist to determine end product testing

Attachment B

Title 16. Board of Pharmacy

Modified Text

To Amend § 1735 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735. Compounding in Licensed Pharmacies.

(a) "Compounding" means any of the following activities occurring in a licensed pharmacy, by or under the supervision of a licensed pharmacist, pursuant to a prescription:
(1) Altering the dosage form or delivery system of a drug
(2) Altering the strength of a drug
(3) Combining components or active ingredients
(4) Preparing a compounded drug product preparation from chemicals or bulk drug substances
(b) "Compounding" does not include reconstitution of a drug pursuant to a manufacturer's direction(s) for oral, rectal, topical, or injectable administration, nor does it include the sole act of tablet splitting or crushing, capsule opening, or the addition of flavoring agent(s) to enhance palatability.
(c) The parameters and requirements stated by this Article 4.5 (Section 1735 et seq.) apply to all compounding practices. Additional parameters and requirements applicable solely to sterile compounding are stated by Article 7 (Section 1751 et seq.).

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1735.1 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.1. Compounding Definitions.

(a) “Ante-area” means an area providing at least an ISO Class 8 or better air quality where personnel hand hygiene and garbing procedures, staging of components, and other high-particulate-generating activities are performed, that is adjacent to the area designated for sterile compounding. It is a transition area that begins the systematic reduction of particles, prevents large fluctuations in air temperature and pressures in the buffer area or cleanroom, and maintains air flows from clean to dirty areas.

(b) “Beyond use date” means the date, or date and time, after which administration of a compounded drug preparation shall not be begun, the preparation shall not be dispensed, and the preparation shall not be stored (other than for quarantine purposes).

(c) “Biological Safety Cabinet (BSC)” means a ventilated cabinet for compounded sterile drug preparations, having an open front with inward airflow for personnel protection, downward HEPA-filtered laminar airflow for product protection, and HEPA-filtered exhausted air for environmental protection.

(d) “Buffer area” means an area which maintains segregation from the adjacent ante-area by means of specific pressure differentials. The principle of displacement airflow shall be employed. This concept utilizes a low pressure differential, high airflow principle. Using displacement airflow typically requires an air velocity of 40 ft per minute or more from the buffer area across the line of demarcation into the ante-area. The displacement concept may not be used to maintain buffer area requirements for sterile compounds which originate from any ingredient that was at any time non-sterile, regardless of intervening sterilization of the ingredient, for hazardous compounds, or for chemotherapy compounds.

(e) “Bulk drug substance” means any substance that, when used in the preparation of a compounded drug preparation, processing, or packaging of a drug, becomes an active ingredient or a finished dosage form of the drug, but the term does not include any intermediate used in the synthesis of such substances.

(f) “Cleanroom” means a physically separate room with walls and doors that provides at least an ISO Class 7 or better air quality where the primary engineering control (PEC) is physically located. A minimum differential positive pressure of 0.02- to 0.05-inch water column is required.

(g) “Compounding Aseptic Isolator (CAI)” means a form of isolator specifically designed for compounding pharmaceutical ingredients or preparations. It is designed to maintain an aseptic compounding environment within the isolator throughout the compounding and material transfer processes. Air exchange into the isolator from the surrounding environment should not occur unless the air has first passed through a microbial retentive filter (HEPA minimum) system capable of containing airborne concentrations of the physical size and state of the drug being compounded.

(h) “Compounding Aseptic Containment Isolator (CACI)” means a compounding aseptic isolator (CAI) designed to provide worker protection from exposure to undesirable levels of airborne drug throughout the compounding and material transfer processes and to provide an aseptic environment for compounding sterile preparations. Air exchange with the surrounding environment should not occur unless the air is first passed through a microbial retentive filter (HEPA minimum) system capable of containing airborne concentrations of the physical size and state of the drug being compounded. Where volatile hazardous drugs are prepared, the exhaust air from the isolator should be appropriately removed by properly designed building ventilation.

(i) “Controlled cold temperature” means 2 degrees to 8 degrees C (35.6 degrees to 46.4 degrees F) (USP37-NF32).

(j) “Controlled freezer temperature” means -25 degrees to -10 degrees C (-13 degrees to 14 degrees F) or at a range otherwise specified by the pharmaceutical manufacturer.

(k) “Controlled room temperature” means 20 degrees to 25 degrees C (68 degrees to 77 degrees F).

(l) “Copy or essentially a copy” of a commercially available drug product includes all preparations that are comparable in active ingredients to commercially available drug products, except that it does not include any preparations in which there has been a

change, made for an identified individual patient, which produces for that patient a significant difference, as determined by a prescribing practitioner, between that compounded preparation and the comparable commercially available drug product.

(m) “Daily” means occurring every day that a pharmacy is operating.

(n) “Dosage unit” means a quantity sufficient for one administration to one patient, except that for self-administered ophthalmic drops, a quantity sufficient for 30 days or less shall be considered one dosage unit.

(o) “Equipment” means items that must be calibrated, maintained or periodically certified.

(p) “First air” means the air exiting the HEPA filter in a unidirectional air stream that is essentially particle free.

(q) “Gloved fingertip sampling” means a process whereby compounding personnel lightly press each fingertip and thumb onto appropriate growth media, which are then incubated at a temperature and for a time period conducive to multiplication of microorganisms, and then examined for growth of microorganisms.

(r) “Hazardous” means all anti-neoplastic agents identified by the National Institute for Occupational Safety and Health (NIOSH) as meeting the criteria for a hazardous drug and any other drugs, compounds, or materials identified as hazardous by the pharmacist-in-charge.

(s) “Integrity” means retention of potency until the beyond use date provided on the label, so long as the preparation is stored and handled according to the label directions after it is dispensed.

(t) “Lot” means one or more compounded drug preparation(s) prepared during one uninterrupted continuous cycle of compounding from one or more common active ingredient(s).

(u) “Media-fill test” means a test that mimics compounding procedures using a growth-based media to demonstrate that aseptic techniques of compounding personnel or processes routinely employed do not result in microbial contamination. To be valid, media-fill tests must be conducted on both the most routine and the most challenging compounding procedures performed.

(v) “Non-sterile-to-sterile batch” means any compounded drug preparation containing two (2) or

more dosage units with any ingredient that was at any time non-sterile, regardless of intervening sterilization of that ingredient.

(w) “Parenteral” means a preparation of drugs administered in a manner other than through the digestive tract. This includes, but is not limited to, injection through one or more layers of skin, administration into the eye, and by inhalation.

(x) “Personal protective equipment” means clothing or devices that protect the employee from exposure to drug products and minimize the contamination of compounded preparations. These include shoe covers, head and facial hair covers, face masks, gowns, and gloves.

(y) “Potency” means active ingredient strength within +/- 10% (or the range specified in USP37-NF32, 37th Revision, Through 2nd Supplement Effective December 1, 2014) of the labeled amount.

(z) “Preparation” means a drug or nutrient compounded in a licensed pharmacy; the preparation may or may not be sterile.

(aa) "Prescriber's office" or "prescriber office" means an office or suite of offices in which a prescriber regularly sees patients for outpatient diagnosis and treatment. This definition does not include any hospital, pharmacy, or other facility, whether or not separately licensed, that may be affiliated with, adjacent to, or co-owned by, the prescriber’s practice environment.

(ab) “Primary Engineering Control (PEC)” means a device that provides an ISO Class 5 or better environment through the use of unidirectional HEPA-filtered first air for the exposure of critical sites when compounding sterile preparations. Examples of PEC devices include, but are not limited to, laminar airflow workbenches, biological safety cabinets, compounding aseptic isolators, and compounding aseptic containment isolators.

(ac) “Process validation” means demonstrating that when a process is repeated within specified limits, the process will consistently produce preparations complying with predetermined requirements. If any aspect of the process is changed, the process would need to be revalidated.

(ad) “Product” means a commercially manufactured drug or nutrient evaluated for safety and efficacy by the FDA.

(ae) “Quality” means the absence of harmful levels of contaminants, including filth, putrid, or decomposed substances, the absence of active ingredients other than those listed on the label, and the absence of inactive ingredients other than those listed on the master formula record.
(af) “Segregated sterile compounding area” means a designated space for sterile-to-sterile compounding where a PEC is located within either a demarcated area (at least three foot perimeter) or in a separate room. Such area or room shall not contain and shall be void of activities and materials that are extraneous to sterile compounding. The segregated sterile compounding area shall not be in a location that has unsealed windows or doors that connect to the outdoors, in a location with high traffic flow, or in a location that is adjacent to construction sites, warehouses, or food preparation. The segregated sterile compounding area shall not have a sink, other than an emergency eye-washing station, located within three feet of the PEC. The segregated sterile compounding area shall be restricted to preparing non-hazardous sterile-to-sterile compounded preparations.
(ag) “Strength” means amount of active ingredient per unit of a compounded drug product preparation.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1735.2 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.2. Compounding Limitations and Requirements; Self-Assessment.

(a) Except as specified in (b) and (c), no drug preparation shall be compounded prior to receipt by a pharmacy of a valid prescription for an individual patient where the prescriber has approved use of a compounded drug preparation either orally or in writing. Where approval is given orally, that approval shall be noted on the prescription prior to compounding. (b) A pharmacy may prepare and store a limited quantity of a compounded drug preparation in advance of receipt of a patient-specific prescription where and solely in such quantity as is necessary to ensure continuity of care for an identified population of patients of the pharmacy

based on a documented history of prescriptions for that patient population.

(c) A “reasonable quantity” that may be furnished to a prescriber for office use by the prescriber as authorized by Business and Professions Code section 4052, subdivision (a)(1), means that amount of compounded drug preparation that:

(1) Is ordered by the prescriber or the prescriber’s agent and paid for by the prescriber at a price that fairly reflects the fair market value of each drug preparation, using a purchase order or other documentation received by the pharmacy prior to furnishing that lists the number of patients seen or to be seen in the prescriber’s office for whom the drug is needed or anticipated, and the quantity for each patient that is sufficient for either office administration or furnishing of a 72-hour supply; and

(2) Is delivered to the prescriber’s office and signed for by the prescriber or the prescriber’s agent; and

(3) Is sufficient for administration or application to patients solely in the prescriber's office, or for furnishing of not more than a 72-hour supply for human medical practices, or a 120-hour supply for veterinary medical practices, solely to the prescriber's own patients seen as part of regular treatment in the prescriber's office, as fairly estimated by the prescriber and documented on the purchase order or other documentation submitted to the pharmacy prior to furnishing; and

(4) That the pharmacist has a credible basis for concluding is reasonable considering the intended use of the compounded medication and the nature of the prescriber’s practice; and

(5) With regard to any individual prescriber to whom the pharmacy furnishes, and with regard to all prescribers to whom the pharmacy furnishes, is an amount which the pharmacy is capable of compounding in compliance with pharmaceutical standards for integrity, potency, quality and strength of the compounded drug preparation; and

(6) Does not exceed an amount the pharmacy can reasonably and safely compound.

(d) No pharmacy or pharmacist shall compound a drug preparation that:

(1) Is classified by the FDA as demonstrably difficult to compound;

(2) Appears on an FDA list of drugs that have been withdrawn or removed from the market because such drugs or components of such drugs have been found to be unsafe or not

effective; or

(3) Is a copy or essentially a copy of one or more commercially available drug products, unless that drug product appears on an ASHP (American Society of Health-System Pharmacists) or FDA list of drugs that are in short supply at the time of compounding and at the time of dispense, and the compounding of that drug preparation is justified by a specific, documented medical need made known to the pharmacist prior to compounding. The pharmacy shall retain a copy of the documentation of the shortage and the specific medical need in the pharmacy records for three years from the date of receipt of the documentation.

(e) A drug preparation shall not be compounded until the pharmacy has first prepared a written master formula record that includes at least the following elements: (1) Active ingredients to be used.

(2) Equipment to be used.

(3) The maximum allowable beyond use date for the preparation, and the rationale or reference source justifying its determination.

(4) Inactive ingredients to be used.

(5) Specific compounding steps used to prepare the drug.

(6) Quality reviews required at each step in preparation of the drug.

(7) Post-compounding process or procedures required, if any.

(8) Instructions for storage and handling of the compounded drug preparation.

(f) Where a pharmacy does not routinely compound a particular drug preparation, the master formula record for that preparation may be recorded on the prescription document itself.

(g) The pharmacist performing or supervising compounding is responsible for the integrity, potency, quality, and labeled strength of a compounded drug preparation until the beyond use date indicated on the label, so long as label instructions for storage and handling are followed after the preparation is dispensed.

(h) All chemicals, bulk drug substances, drug products, and other components used for drug compounding shall be stored and used according to compendial and other applicable requirements to maintain their integrity, potency, quality, and labeled strength.

(i) Every compounded drug preparation shall be given beyond use date representing the date beyond which, in the professional judgment of the pharmacist performing or supervising the compounding, it should not be used, stored, transported, or administration begun. This "beyond use date" of the compounded drug preparation shall not exceed the shortest expiration date of any component in the compounded drug preparation, nor shall it exceed 180 days from preparation unless a later date is supported by stability studies of finished drugs or compounded drug preparations using identical components and packaging. Shorter dating than set forth in this subsection may be used if it is deemed appropriate in the professional judgment of the responsible pharmacist.

(j) The pharmacist performing or supervising compounding is responsible for the proper preparation, labeling, storage, and delivery of the compounded drug preparation.

(k) Packages of ingredients, both active and inactive, that lack a supplier's expiration date are subject to the following limitations:

(1) Such ingredients cannot be used for any non-sterile compounded drug preparation more than three (3) years after the date of receipt by the pharmacy unless either appropriate and documented inspection or analytical testing indicates that the ingredient has retained its purity and quality for use in compounded drug preparations, considering the container in which it is packaged and the storage conditions, and

(2) Such ingredients cannot be used for any sterile compounded drug preparation more than one (1) year after the date of receipt by the pharmacy, unless either appropriate and documented inspection or analytical testing indicates that the ingredient has retained its purity and quality for use in compounded drug preparations, considering the container in which it is packaged and the storage conditions.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code, Sections 1735, 1735.1, 1735.8, and 1751.1-1751.8 of Title 16, Division 17, of the California Code of Regulations.

To Amend § 1735.3 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.3. Recordkeeping for Compounded Drug Preparations.

(a) For each compounded drug preparation, pharmacy records shall include:
(1) The master formula record.
(2) The date the drug preparation was compounded.
(3) The identity of any pharmacy personnel engaged in compounding the drug preparation.
(4) The identity of the pharmacist reviewing the final drug preparation.
(5) The quantity of each component used in compounding the drug preparation.
(6) The manufacturer, expiration date and lot number of each component. If the manufacturer name is demonstrably unavailable, the name of the supplier may be substituted. If the manufacturer does not supply an expiration date for any component, the records shall include the date of receipt of the component in the pharmacy, and the limitations of section 1735.2, subdivision (k) shall apply. Exempt from the requirements in this paragraph are sterile preparations compounded in a single lot for administration within seventy-two (72) hours to an inpatient in a health care facility licensed under section 1250 of the Health and Safety Code and stored in accordance with standards for "Redispensed CSPs" found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference.
(7) A pharmacy-assigned reference or lot number for the compounded drug preparation.
(8) The beyond use date or beyond use date and time of the final compounded drug preparation, expressed in the compounding record in a standard date and time format.
(9) The final quantity or amount of drug preparation compounded for dispensing.
(b) Pharmacies shall maintain records of the proper acquisition, storage, and destruction of chemicals, bulk drug substances, drug products, and components used in compounding.
(c) Active ingredients shall be obtained from a supplier registered with the Food and Drug Administration (FDA). All other chemicals, bulk drug substances, and drug products used

to compound drug preparations shall be obtained, whenever possible, from FDA-registered suppliers. The pharmacy shall acquire and retain certificates of purity or analysis, either written in English or translated into English, for chemicals, bulk drug substances, and drug products used in compounding. Certificates of purity or analysis are not required for drug products that are approved by the FDA. Any certificates of purity or analysis acquired by the pharmacy shall be matched to the corresponding product received.

(d) Pharmacies shall maintain and retain all records required by this article in the pharmacy in a readily retrievable form for at least three years from the date the record was created. If only recorded and stored electronically, on magnetic media, or in any other computerized form, the records shall be maintained as specified by Business and Professions Code section 4070 subsection (c).

Authority cited: Sections 4005, 4127, and 4169, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1735.4 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.4. Labeling of Compounded Drug Preparations.

(a) In addition to the labeling information required under Business and Professions Code section 4076, the label of a compounded drug preparation shall contain the generic or brand name(s) of the principal active ingredient(s).

(b) A statement that the drug has been compounded by the pharmacy shall be included on the container provided to the patient. Exempt from the requirements of this paragraph are those sterile drug preparations compounded within a health care facility solely for administration, by a licensed health care professional, to a patient of the facility. To be treated as such, the "health care facility" must be licensed under Health and Safety Code section 1250.

(c) Drug preparations compounded into unit-dose containers that are too small or otherwise

impractical for full compliance with subdivisions (a) and (b) shall be labeled with at least the name of the compounding pharmacy and dispensing pharmacy, if different, the name(s) of the active ingredient(s), strength, volume or weight of the preparation, pharmacy reference or lot number, and beyond use date.

Note: Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, 4076 and 4127, Business and Professions Code.

To Amend § 1735.5 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.5. Compounding Policies and Procedures.

(a) Any pharmacy engaged in compounding shall maintain a written policies and procedures manual for compounding that establishes procurement procedures, methodologies for the formulation and compounding of drugs, facilities and equipment cleaning, maintenance, operation, and other standard operating procedures related to compounding. Any failure to follow the pharmacy's written policies and procedures shall constitute a basis for disciplinary action.

(b) The policies and procedures manual shall be reviewed and such review shall be documented on an annual basis by the pharmacist-in-charge. The policies and procedures manual shall be updated whenever changes in policies and procedures are implemented.

(c) The policies and procedures manual shall include at least the following:

(1) Procedures for notifying staff assigned to compounding duties of any changes in policies or procedures.

(2) A written plan for recall of a dispensed compounded drug preparation where subsequent information demonstrates the potential for adverse effects with continued use. The plan shall ensure that all affected doses can be accounted for during the recall.

(3) The procedures for maintaining, storing, calibrating, cleaning, and disinfecting equipment used in compounding, and for training on these procedures as part of the staff training and competency evaluation process.

(4) The procedures for evaluating, maintaining, certifying, cleaning, and disinfecting the facility (physical plant) used for compounding, and for training on these procedures as part of the staff training and competency evaluation process.

(5) Documentation of the methodology used to validate integrity, potency, quality, and labeled strength of compounded drug preparations. The methodology must be appropriate to compounded drug preparations.

(6) Documentation of the methodology and rationale or reference source used to determine appropriate beyond use dates for compounded drug preparations.

(7) Dates and signatures reflecting all annual reviews of the policies and procedures manual by the pharmacist-in-charge.

(8) Dates and signatures accompanying ~~of~~ any revisions to the policies and procedures manual approved by the pharmacist-in-charge.

(9) Policies and procedures for storage of compounded drug preparations in the pharmacy and daily documentation of all room, refrigerator, and freezer temperatures within the pharmacy.

(10) Policies and procedures regarding ensuring appropriate functioning of refrigeration devices, monitoring refrigeration device temperatures, and actions to take regarding any out of range temperature variations within the pharmacy.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, 4127, and 4301, Business and Professions Code.

To Amend § 1735.6 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.6. Compounding Facilities and Equipment.

(a) Any pharmacy engaged in compounding shall maintain written documentation regarding the facilities and equipment necessary for safe and accurate compounded drug preparations. This shall include records of maintenance and cleaning of the facilities and equipment. Where applicable, this shall also include records of certification(s) of facilities or equipment.

(b) Any equipment used to compound drug preparations shall be stored, used, maintained, and cleaned in accordance with manufacturers' specifications.

(c) Any equipment that weighs, measures, or transfers ingredients used to compound drug preparations for which calibration or adjustment is appropriate shall be calibrated prior to use, on a schedule and by a method determined by the manufacturer's specifications, to ensure accuracy. Documentation of each such calibration shall be recorded in a form which is not alterable and these records of calibration shall be maintained and retained in the pharmacy.

(d) Any pharmacy engaged in any hazardous drug compounding shall maintain written documentation regarding appropriate cleaning of facilities and equipment to prevent cross-contamination with non-hazardous drugs.

Note: Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052 and 4127, Business and Professions Code.

To Amend § 1735.7 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.7. Training of Compounding Staff.

(a) Any pharmacy engaged in compounding shall maintain written documentation sufficient to demonstrate that pharmacy personnel have the skills and training required to properly and accurately perform their assigned responsibilities relating to compounding. Additionally, documentation demonstrating that staff have been trained on all policies and procedures shall be maintained.

(b) The pharmacy shall develop and maintain an ongoing competency evaluation process for Pharmacy personnel involved in compounding, and shall maintain documentation of any and all training related to compounding undertaken by pharmacy personnel.

(c) Pharmacy personnel assigned to compounding duties shall demonstrate knowledge about processes and procedures used in compounding prior to compounding any drug preparation.

Note: Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052 and 4127, Business and Professions Code.

To Amend § 1735.8 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.8. Compounding Quality Assurance.

(a) Any pharmacy engaged in compounding shall maintain, as part of its written policies and procedures, a written quality assurance plan designed to monitor and ensure the integrity, potency, quality, and labeled strength of compounded drug preparations.
(b) The quality assurance plan shall include written procedures for verification, monitoring, and review of the adequacy of the compounding processes and shall also include written documentation of review of those processes by qualified pharmacy personnel.
(c) The quality assurance plan shall include written standards for qualitative and quantitative analysis of compounded drug preparations to ensure integrity, potency, quality, and labeled strength, including the frequency of testing, of compounded drug preparations. All qualitative and quantitative analysis reports for compounded drug preparations shall be retained by the pharmacy and maintained along with the compounding record and master formula. The quality assurance plan shall include a schedule for routine testing and analysis of compounded drug preparations to ensure integrity, potency, quality, and labeled strength, on at least an annual basis.
(d) The quality assurance plan shall include a written procedure for scheduled action in the event any compounded drug preparation is ever discovered to be below minimum standards for integrity, potency, quality, or labeled strength.
(e) The quality assurance plan shall include a written procedure for responding to out-of-range temperature variations within the pharmacy or within patient care areas of a hospital where a furnished drug is returned for redispensing.

Note: Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052 and 4127, Business and Professions Code.

To Amend § 1751 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

Article 7. Sterile Compounding

1751. Sterile Compounding; Compounding Area; Self-Assessment.

(a) Any pharmacy engaged in compounding sterile drug preparations shall conform to the parameters and requirements stated by Article 4.5 (Section 1735 et seq.), applicable to all compounding, and shall also conform to the parameters and requirements stated by this Article 7 (Section 1751 et seq.), applicable solely to sterile compounding.

(b) Any pharmacy compounding sterile drug preparations shall have a compounding area designated for the preparation of sterile drug preparations that is in a restricted location where traffic has no impact on the performance of the PEC(s). The buffer area or cleanroom, including the walls, ceilings, and floors, shall be constructed in accordance with Section 1250.4 of Title 24, Part 2, Chapter 12, of the California Code of Regulations. The pharmacy shall be ventilated in a manner in accordance with Section 505.5 of Title 24, Part 4, Chapter 5 of the California Code of Regulations. The environments within the pharmacy shall meet the following standards:

(1) Each ISO environment shall be certified at least every six months by a qualified technician in accordance with Section 1751.4. Certification records must be retained in the pharmacy.

(2) Items related to the compounding of sterile drug preparations within the compounding area shall be stored in such a way as to maintain the integrity of an aseptic environment.

(3) A sink shall be included in accordance with Section 1250.4 of Title 24, Part 2, Chapter 12, of the California Code of Regulations. Sinks and drains shall not be present in any ISO Class 7 or better buffer area or cleanroom, nor in a segregated sterile compounding area within three feet of an ISO Class 5 or better PEC, with the exception of emergency eye-rinsing stations. A sink may be located in an ante-area.

(4)There shall be a refrigerator and, where appropriate, a freezer, of sufficient capacity to

meet the storage requirements for all material requiring refrigeration or freezing, and a backup plan to ensure continuity of available compounded drug preparations in the event of a power outage.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code; Sections 1735, 1735.1,-1735.8., and 1751.1-1751.8. of Title 16, Division 17, of the California Code of Regulations; and Section 18944, Health and Safety Code.

To Amend § 1751.1 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.1. Sterile Compounding Recordkeeping Requirements.

(a) In addition to the records required by section 1735.3, any pharmacy engaged in any compounding of sterile drug preparations, shall make and keep the following records within the pharmacy:

(1) Documents evidencing training and competency evaluations of employees in sterile drug preparation policies and procedures.

(2) Results of hand hygiene and garbing assessments with integrated gloved fingertip testing.

(3) Results of assessments of personnel for aseptic techniques including results of media-fill tests and gloved fingertip testing performed in association with media-fill tests.

(4) Results of viable volumetric air and surface sampling.

(5) Documents indicating daily recordation of room, refrigerator, and freezer temperatures appropriate for sterile compounded drug preparations consistent with the temperatures listed in section 1735.1 for:

(A) Controlled room temperature.

(B) Controlled cold temperature.

(C) Controlled freezer temperature.

(6) Certification(s) of the sterile compounding environment(s).

(7) Documents indicating daily recordation of air pressure differentials or air velocity measurements between all adjoining ~~all~~ ISO rooms or areas, including those associated with compounding aseptic (containment) isolators, and air pressure differentials or air velocity measurements between all rooms or spaces with an immediate entry or opening to ISO rooms or areas.

(8) Other facility quality control records specific to the pharmacy's policies and procedures (e.g., cleaning logs for facilities and equipment).

(9) Logs or other documentation of inspections for expired or recalled chemicals, bulk drug substances, drug products, or other ingredients.

(10) Preparation records including the master work sheet, the preparation work sheet, and records of end-product evaluation results.

(b) Pharmacies compounding sterile drug preparations for future use pursuant to section 1735.2 shall, in addition to those records required by section 1735.3, make and keep records indicating the name, lot number, and amount of any drug preparation compounded for future use, the date on which any preparation was provided to a prescriber, and the name, address, and license number of the prescriber.

(c) Pharmacies shall maintain and retain all records required by this article in the pharmacy in a readily retrievable form for at least three years from the date the record was created. If only recorded and stored electronically, on magnetic media, or in any other computerized form, the records shall be maintained as specified by Business and Professions Code section 4070 subsection (c).

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.2 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.2. Sterile Compounding Labeling Requirements.

In addition to the labeling information required under Business and Professions Code section 4076 and California Code of Regulations section 1735.4, a pharmacy that compounds sterile drug preparations shall include the following information on the label for each such preparation:

(a) The telephone number of the pharmacy. The telephone number is not required on the label for sterile drug preparations dispensed to patients within the hospital.

(b) Name and strength, volume, or weight of each ingredient contained in the sterile drug preparation.

(c) Instructions for storage and handling.

(d) All hazardous agents shall bear a special label which states Hazardous – Dispose of Properly" or "Chemotherapy - Dispose of Properly."

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, 4076 and 4127, Business and Professions Code.

To Amend § 1751.3 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.3. Sterile Compounding Policies and Procedures.

(a) Any pharmacy engaged in compounding sterile drug preparations shall maintain a written policies and procedures manual for compounding that includes, in addition to the elements required by section 1735.5, written policies and procedures regarding the following:

(1) Compounding, filling, and labeling of sterile drug preparations.

(2) Labeling of sterile compounded drug preparations based on the intended route of administration and recommended rate of administration.

(3) Proper use of equipment and supplies.

(4) Hand hygiene and garbing.

(5) Media-fill testing procedure.

(6) Quality assurance program.

(7) Record keeping requirements.

(8) Compounded sterile drug preparation stability and beyond use dating.

(9) Visual inspection and other final quality checks of sterile drug preparations.

(10) Use of automated compounding devices (if applicable).

(11) Preparing sterile compounded drug preparations from non-sterile components (if applicable).

(12) Orientation, training, and competency evaluation of staff in all aspects of the preparation of sterile drug preparations including didactic training and knowledge/competency assessments that include at minimum: hand hygiene and garbing; decontamination (where applicable); cleaning and disinfection of controlled compounding areas; and proper aseptic technique.

(13) Airflow considerations and pressure differential monitoring.

(14) Cleaning and maintenance of ISO environments and segregated compounding areas.

(15) An environmental sampling plan and procedures specific to viable air, surface and gloved fingertip sampling as well as nonviable particle sampling.

(16) For compounding aseptic isolators and compounding aseptic containment isolators, documentation of the manufacturer's recommended purge time.

(17) Temperature monitoring in compounding and controlled storage areas.

(18) Facility management including certification and maintenance of controlled environments and related equipment.

(19) Action levels for colony-forming units (CFUs) detected during viable surface testing, glove fingertip and volumetric air sampling.

(20) The determination and approval by a pharmacist of ingredients and the compounding process for each preparation before compounding begins.

(21) Procedures for handling, compounding and disposal of hazardous agents. The written policies and procedures shall describe the pharmacy protocols for cleanups and spills in

conformity with local health jurisdiction standards.

(22) Procedures for handling, compounding and disposal of infectious materials. The written policies and procedures shall describe the pharmacy protocols for cleanups and spills in conformity with local health jurisdiction standards.

(23) Daily and monthly cleaning and disinfection schedule for the controlled areas and any equipment in the controlled area as specified in section 1751.4.

(b) For lot compounding, the pharmacy shall maintain a written policies and procedures manual that includes, in addition to the elements required by section 1735.5 and 1751.3(a), written policies and procedures regarding the following:

(1) Use of master formulas and compounding work sheets

(2) Appropriate documentation

(3) Appropriate sterility and potency testing.

(c) For non-sterile-to-sterile batch compounding, the pharmacy shall maintain a written policies and procedures manual for compounding that includes, in addition to the elements required by section 1735.5 and 1751.3(a), written policies and procedures regarding the following:

(1) Sterilization methods

(2) End-product evaluation and testing

(d) All written policies and procedures manuals and materials shall be immediately available to all personnel involved in compounding activities and to board inspectors.

(e) All personnel involved must read the policies and procedures before compounding sterile drug preparations, and any additions, revisions, and deletions to the written policies and procedures must be communicated to all personnel involved in sterile compounding. This review must be documented by a signature and date.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.4 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.4. Facility and Equipment Standards for Sterile Compounding.

(a) No sterile drug preparation shall be compounded if it is known, or reasonably should be known, that the compounding environment fails to meet criteria specified in the pharmacy's written policies and procedures for the safe compounding of sterile drug preparations.

(b) During the compounding of sterile drug preparations, access to the areas designated for compounding must be limited to those individuals who are properly attired.

(c) All equipment used in the areas designated for compounding must be made of a material that can be easily cleaned and disinfected.

(d) Cleaning and disinfecting surfaces in the ISO Class 5 PEC shall occur frequently, including:

(1) at the beginning of each shift;

(2) before and after each lot;

(3) after each spill; and

(4) when surface contamination is known or suspected.

(e) Counters, cleanable work surfaces and floors shall be cleaned with a germicidal detergent and water and disinfected with a suitable agent daily. Walls, ceilings, storage shelving, tables and stools shall be cleaned with a germicidal detergent and water and disinfected with a suitable agent monthly. Cleaning and disinfecting shall occur after any unanticipated event that could increase the risk of contamination.

(f) Pharmacies preparing sterile compounded preparations require the use of a PEC that provides ISO Class 5 air or better air quality. Certification and testing of primary and secondary engineering controls shall be performed no less than every six months and whenever the device or area designated for compounding is relocated, altered or a service to the facility is performed that would impact the device or area. Certification must be completed by a qualified technician who is familiar with certification methods and procedures in accordance with CETA Certification Guide for Sterile Compounding Facilities (CAG-003-2006-11, Revised January 31, 2012). Certification records must be retained for at least 3 years. Compounding

aseptic isolators or compounding aseptic containment isolators may be used outside of an ISO Class 7 buffer area or cleanroom if the isolator meets the following criteria:

(1) particle counts sampled approximately 6-12 inches upstream of the critical exposure site shall maintain ISO Class 5 levels during compounding operations.

(2) not more than 3520 particles (0.5 um and larger) per cubic meter shall be counted during material transfer, with the particle counter probe located as near to the transfer door as possible without obstructing transfer.

(3) recovery time to achieve ISO Class 5 air quality shall be documented and internal procedures developed to ensure that adequate recovery time is allowed after material transfer before and during compounding operations.

Compounding aseptic isolators or compounding aseptic containment isolators that do not meet the requirements as outlined in this subdivision or are not located within an ISO Class 7 buffer area may only be used to compound preparations that meet the criteria specified in accordance with subdivision (d) of Section 1751.8 of Title 16, Division 17, of the California Code of Regulations.

(g) Pharmacies preparing sterile hazardous agents shall do so in accordance with Section 505.5.1 of Title 24, Chapter 5, of the California Code of Regulations, requiring a negative pressure PEC. The negative pressure PEC must be certified every six months by a qualified technician who is familiar with CETA Certification Guide for Sterile Compounding Facilities (CAG-003-2006-11, Revised January 31, 2012). Any drug preparation that is compounded in a PEC where hazardous drugs are prepared must be labeled as hazardous, regardless of whether the drug ingredients are considered hazardous.

During the hazardous drug compounding that is performed in a compounding aseptic containment isolator, full hand hygiene and garbing must occur, complete with hair cover, facemask, beard cover (if applicable), polypropylene or low shedding gown that closes in the back, shoe covers, and two layers of gloves with the outermost glove tested to meet ASTM 6978-05. Where the documentation provided by CACI manufacturer does not require garbing, only the two glove requirement shall apply.

(h) If a compounding aseptic isolator is certified by the manufacturer to maintain ISO Class 5 air

quality during dynamic operation conditions during compounding as well as during the transfer of ingredients into and out of the compounding aseptic isolator, then it may be placed into a non-ISO classified room. Individuals that use compounding aseptic isolators in this manner must ensure appropriate garbing, which consists of donning sterile gloves over the isolator gloves immediately before non-hazardous compounding. These sterile gloves must be changed by each individual whenever continuous compounding is ceased and before compounding starts again.

(i) Viable surface sampling shall be done at least quarterly for all sterile-to-sterile compounding and monthly for all non-sterile-to-sterile compounding. Volumetric air sampling by impaction shall be done at least once every six months. Viable surface and volumetric air sampling shall be performed by a qualified individual who is familiar with the methods and procedures for surface testing and air sampling. Viable air sampling is to be performed under dynamic conditions that simulate actual production. Surface sampling is to be performed under dynamic conditions of actual compounding. When the environmental monitoring action levels are exceeded, the pharmacy shall identify the CFUs at least to the genus level in addition to conducting an investigation. Remediation shall include an immediate investigation of cleaning and compounding operations and facility management.

(j) The pharmacy shall have a comfortable and well-lighted working environment, which includes a room temperature of 20 degrees Celsius (68 degrees Fahrenheit) or cooler to maintain comfortable conditions for compounding personnel when attired in the required compounding garb.

Note: Authority Cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052 and 4127, Business and Professions Code; and Section 18944, Health and Safety Code.

To Amend § 1751.5 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.5. Sterile Compounding Attire.

(a) When compounding sterile drug preparations the following standards must be met:

(1) Personal protective equipment consisting of a non-shedding gown, head cover, face mask, facial hair covers (if applicable), and shoe covers must be worn inside the designated area at all times, unless the compounding aseptic isolator or compounding aseptic containment isolator manufacturer can provide written documentation, based on validated environmental testing, that any component of the personal protective equipment or personnel cleansing is not required.

(2) Personal protective equipment must be donned and removed in an ante-area or immediately outside the segregated compounding area.

(3) Personnel shall don personal protective equipment in an order that proceeds from those activities considered the dirtiest to those considered the cleanest. The following order is to be followed unless the pharmacy has a procedure in place that documents a method equivalent to or superior to the method described here: The donning of shoe covers or dedicated shoes, head and facial hair covers and face masks shall be followed by the washing of hands and forearms up to the elbows for 30 seconds with soap and water, drying hands, and then the donning of a non-shedding gown.

(4) Compounding personnel shall not wear hand, finger, or wrist jewelry. If jewelry cannot be removed then it must be thoroughly cleaned and covered with a sterile glove.

(5) Sterile gloves that have been tested for compatibility with disinfection with isopropyl alcohol are required. Hand cleansing with a persistently active alcohol-based product followed by the donning of sterile gloves may occur within the ante or buffer area or cleanroom. Gloves are to be routinely disinfected with sterile 70 percent isopropyl alcohol before entering or re-entering the PEC and after contact with non-sterile objects. Gloves shall also be routinely inspected for holes, punctures, or tears and replaced immediately if such are detected.

(6) Individuals experiencing rashes, sunburn, weeping sores, conjunctivitis, active respiratory infections, or those wearing cosmetics shall be excluded from the ISO Class 5 and ISO Class 7 compounding areas until their conditions are remedied.
(b) When preparing hazardous agents, appropriate gowns and personal protective equipment shall be worn regardless of the PECs used (e.g., biological safety cabinet and compounding aseptic containment isolator).

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.6 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.6 Sterile Compounding Consultation; Training of Sterile Compounding Staff.
(a) Consultation shall be available to the patient and/or primary caregiver concerning proper use, storage, handling, and disposal of sterile drug preparations and related supplies furnished by the pharmacy.
(b) The pharmacist-in-charge shall ensure that all pharmacy personnel engaging in compounding sterile drug preparations have training and demonstrated competence in the safe handling and compounding of sterile drug preparations, including hazardous agents if the pharmacy compounds products with hazardous agents.
(c) Records of training and demonstrated competence shall be available for each individual and shall be retained for three years beyond the period of employment.
(d) The pharmacist-in-charge shall be responsible to ensure the continuing competence of pharmacy personnel engaged in compounding sterile drug preparations.
(e) Pharmacies that compound sterile drug preparations must comply with the following training requirements:
(1) The pharmacy must establish and follow a written program of training and performance

evaluation designed to ensure that each person working in the designated area has the knowledge and skills necessary to perform their assigned tasks properly. This program of training and performance evaluation must address at least the following:

(A) Aseptic technique.

(B) Pharmaceutical calculations and terminology.

(C) Sterile preparation compounding documentation.

(D) Quality assurance procedures.

(E) Aseptic preparation procedures using media fill tests which are as complicated as the most complex manipulations performed by staff and which contain the same amount or greater of volume transferred during the selected manipulations.

(F) Proper hand hygiene, gowning and gloving technique.

(G) General conduct in the controlled area.

(H) Cleaning, sanitizing, and maintaining of the equipment and the controlled area.

(I) Sterilization techniques for compounding sterile drug preparations from one or more non-sterile ingredients.

(J) Container, equipment, and closure system selection.

(2) Each person engaged in sterile compounding must successfully complete practical skills training in aseptic technique and aseptic area practices. Evaluation must include written testing and a written protocol of periodic routine performance checks involving adherence to aseptic area policies and procedures. Each person's proficiency and continuing training needs must be reassessed at least every 12 months. Results of these assessments must be documented and retained in the pharmacy for three years.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.7 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.7. Sterile Compounding Quality Assurance and Process Validation.

(a) Any pharmacy engaged in compounding sterile drug preparations shall maintain, as part of its written policies and procedures, a written quality assurance plan including, in addition to the elements required by section 1735.8, a documented, ongoing quality assurance program that monitors personnel performance, equipment, and facilities. The end product shall be examined on a periodic sampling basis as determined by the pharmacist- in-charge to assure that it meets required specifications. The quality assurance program shall include at least the following:

(1) Procedures for cleaning and sanitization of the sterile preparation area.

(2) Actions to be taken in the event of a drug recall.

(3) Documentation justifying the chosen beyond use dates for compounded sterile drug preparations.

(b) Each individual involved in the preparation of sterile-drug preparations must first successfully demonstrate competency by successfully performing aseptic media fill tests before being allowed to prepare sterile drug preparations. The media fill testing process shall be as complicated as the most complex manipulations performed by staff and contain the same amount or greater of volume transferred during the compounding process. The same personnel, procedures, equipment, and materials must be involved. Media used must have demonstrated the ability to support and promote growth. Completed media samples must be incubated in a manner consistent with the manufacturer's recommendations. If microbial growth is detected, then the employee's sterile preparation process must be evaluated, corrective action taken and documented, and the media fill testing repeated. Personnel competency must be revalidated at least every twelve months for sterile to sterile compounding and at least every six months for individuals compounding sterile products from non-sterile ingredients. Aseptic work practice assessments via media fill tests must be revalidated, as appropriate to the circumstance or personnel found to be deficient, whenever the quality assurance program yields an unacceptable result, when the compounding process

changes, equipment used in the compounding of sterile drug preparations is replaced, the facility is modified in a manner that affects airflow or traffic patterns, or whenever improper aseptic techniques are observed. Revalidation must be documented.

(c) All sterile compounding personnel must successfully complete an initial competency evaluation. In addition, immediately following the initial hand hygiene and garbing procedure, all compounding personnel must successfully complete a gloved fingertip sampling procedure (zero colony forming units for both hands) at least three times before initially being allowed to compound sterile drug preparations.

(d) Re-evaluation of garbing and gloving competency shall occur at least every 12 months for personnel compounding products made from sterile ingredients and at least every six months for personnel compounding products from non-sterile ingredients.

(e) Non-sterile-to-sterile batch drug preparations shall be subject to documented end product testing for sterility and pyrogens and shall be quarantined until the end product testing confirms sterility and acceptable levels of pyrogens, per USP chapter 85 limits, before dispensing. This requirement of end product testing confirming sterility and acceptable levels of pyrogens prior to dispensing shall apply regardless of any sterility or pyrogen testing that may have been conducted on any ingredient or combination of ingredients that were previously non-sterile.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.8 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.8. Beyond Use Dating for Sterile Compounded Drug Preparations.

In conformity with and in addition to the requirements and limitations of section 1735.2, subdivision (h), every sterile compounded drug preparation shall be given and labeled with a beyond use date that does not exceed the expiration date or beyond use date provided by the manufacturer for any component in the preparation, and that, in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference, that would justify a more extended beyond use date, conforms to the following limitations:~~,~~

(a) The beyond use date shall specify that storage and exposure periods cannot exceed 48 hours at controlled room temperature, 14 days at controlled cold temperature, and 45 days at controlled freezer temperature, where the sterile compounded drug preparation is compounded solely with aseptic manipulations and all of the following apply:

(1) The preparation is compounded entirely within an ISO Class 5 PEC located in an ISO Class 7 buffer area or cleanroom with an ante-area, using only sterile ingredients, products, components, and devices; and

(2) The compounding process involves transferring, measuring, and mixing manipulations using not more than three commercially manufactured packages of sterile preparations and not more than two entries into any one sterile container or package of sterile preparations or administration containers/devices to prepare the drug preparation; and

(3) Compounding manipulations are limited to aseptically opening ampules, penetrating disinfected stoppers on vials with sterile needles and syringes, and transferring sterile liquids in sterile syringes to sterile administration devices, package containers of other sterile preparations, and containers for storage dispensing.

(b) The beyond use date shall specify that storage and exposure periods cannot exceed 30 hours at controlled room temperature, 9 days at controlled cold temperature, and 45 days at

controlled freezer temperature, where the sterile compounded drug preparation is compounded solely with aseptic manipulations and all of the following apply:

(1) The preparation is compounded entirely within an ISO Class 5 PEC located in an ISO Class 7 buffer area or cleanroom with an ante-area, using multiple individual or small doses of sterile preparations combined or pooled to prepare a compounded sterile preparation that will be administered either to multiple patients or to one patient on multiple occasions; and

(2) The compounding process involves complex aseptic manipulations other than the single-volume transfer; and

(3) The compounding process requires unusually long duration such as that required to complete dissolution or homogenous mixing.

(c) The beyond use date shall specify that storage and exposure periods cannot exceed 24 hours at controlled room temperature, 3 days at controlled cold temperature, and 45 days at controlled freezer temperature, where the sterile compounded drug preparation is compounded solely with aseptic manipulations using non-sterile ingredients, including manufactured preparations not intended for sterile routes of administration, or non-sterile devices, before terminal sterilization, or where the sterile compounded drug preparation lacks effective antimicrobial preservatives.

For the purposes of this subdivision, “non-sterile” includes sterile contents of commercially manufactured preparations, sterile surfaces of devices, and containers for the preparation, transfer, sterilization, and packaging of compounded sterile preparations, that are exposed to worse than ISO Class 5 air quality for more than one hour.

(d) The beyond use date shall specify that storage and exposure periods cannot exceed 12 hours where the sterile compounded drug preparation is compounded solely with aseptic manipulations and all of the following apply:

(1) The preparation was compounded entirely within an ISO Class 5 PEC that is located in a segregated sterile compounding area and restricted to sterile compounding activities, using only sterile ingredients, components, and devices, by personnel properly cleansed and garbed; and

(2) The compounding process involves simple transfer of not more than three commercially manufactured packages of sterile nonhazardous preparations or diagnostic radiopharmaceutical

preparations from the manufacturer's original containers; and

(3) The compounding process involves not more than two entries into any one container or package (e.g., bag, vial) of sterile infusion solution or administration container/device.

(e)(1) Where any sterile compounded drug preparation was compounded either outside of an ISO class 5 PEC or under conditions that do not meet all of the requirements for any of subdivisions (a) through (e), the sterile compounded drug preparation shall be labeled "for immediate use only" and administration shall begin no later than one hour following the start of the compounding process. Unless the "immediate use" preparation is immediately and completely administered by the person who prepared it or immediate and complete administration is witnessed by the preparer, the preparation shall bear a label listing patient identification information, the names and amounts of all ingredients, the name or initials of the person who prepared the compounded sterile preparation, and the exact one-hour beyond use date and time. If administration has not begun within one hour following the start of the compounding process, the compounded sterile preparation shall be promptly, properly, entirely, and safely discarded. This provision does not preclude the use of a PEC to compound an "immediate use" preparation. A PEC used solely to compound 'immediate use' preparations need not be placed within an ISO Class 7 buffer area or cleanroom, with an ante-area.

(2) Such "immediate use" preparations shall be compounded only in those limited situations where there is a need for immediate administration of a sterile preparation compounded outside of an ISO class 5 environment and where failure to administer could result in loss of life or intense suffering. Any such compounding shall be only in such quantity as is necessary to meet the immediate need and the circumstance causing the immediate need shall be documented in accordance with policies and procedures.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Add § 1751.9 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.9 Single-Dose and Multi-Dose Containers; Limitations on Use

(a) Single-dose ampules are for immediate use only, and once opened shall not be stored for any time period.

(b) Unless otherwise specified by the manufacturer, any single-dose container of a compounded sterile drug preparation other than an ampule, such as a bag, bottle, syringe or vial, shall be used in its entirety or its remaining contents discarded within the following time limit, depending on the environment:

(1) When needle-punctured in an environment with air quality worse than ISO Class 5, within one (1) hour;

(2) When needle-punctured in an environment with ISO Class 5 or better air quality, within six (6) hours.

(c) Unless otherwise specified by the manufacturer, a multi-dose container stored according to the manufacturer's specifications shall be used in its entirety or its remaining contents discarded within twenty eight (28) days from initial opening or puncture. Any multi-dose container not stored according to the manufacturer's specifications shall be discarded immediately upon identification of such storage circumstance.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.10 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.10. Sterile Compounding Reference Materials.

In any pharmacy engaged in compounding sterile drug preparations, there shall be current and appropriate reference materials regarding the compounding of sterile drug preparations located in or immediately available to the pharmacy.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Add Article 7.5 of Division 17 of Title 16 of the California Code of Regulations to read as follow

Article 7.5 Furnishing for Home Administration

To Amend § 1751.10 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1752. Furnishing to Parenteral Patient at Home.

Subject to all provisions of this article, a pharmacist may carry and furnish to a patient at home dangerous drugs, other than controlled substances, and devices for parenteral therapy when the dangerous drug or device is one currently prescribed for the patient.

Authority cited: Section 4005, Business and Professions Code. Reference: Section 4005, Business and Professions Code.

To Amend § 1751.11 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1753. Furnishing to Home Health Agencies and Licensed Hospices.

Subject to the following conditions, a licensed pharmacy may furnish to a home health agency licensed under provisions of Chapter 8 (commencing with section 1725 of Division 2 of the Health and Safety Code) or to a hospice licensed under provisions of Chapter 8.5 (commencing with section 1745 of Division 2 of the Health and Safety Code) dangerous drugs for parenteral therapy other than controlled substances, in a portable container for furnishing to patients at home for emergency treatment or adjustment of parenteral drug therapy by the home health agency or licensed hospice.

(a) The pharmacy, having ownership and responsibility for the portable containers, shall ensure that each portable container is:

(1) furnished by a registered pharmacist;

(2) sealed in such a manner that a tamper-proof seal must be broken to gain access to the drugs;

(3) under the effective control of a registered nurse, pharmacist or delivery person at all times when not in the pharmacy;

(4) labeled on the outside of the container with a list of the contents;

(5) maintained at an appropriate temperature according to United States Pharmacopeia Standards (1995, 23rd Revision), and protected at all times from extreme temperatures that could damage the contents.

(b) The portable container may contain up to:

(1) 1000mL of 0.9% sodium chloride intravenous infusion in containers of a size determined by the pharmacy;

(2) 1000mL of 5% dextrose in water injection in containers of a size determined by the pharmacy;

(3) two vials of urokinase 5000 units;

(4) Each of the following items shall be in sealed, unused containers; the furnishing pharmacy may select any or all of these dangerous drugs in up to five dosage units for inclusion in the sealed, portable container:

(A) heparin sodium lock flush 100 units/mL;

(B) heparin sodium lock flush 10 units/mL;

(C) epinephrine HCl solution 1:1000;

(D) epinephrine HCl solution 1:10,000;

(E) diphenhydramine HCl 50mg/mL;

(F) methylprednisolone 125mg/2mL;

(G) normal saline, preserved, up to 30 mL vials;

(H) naloxone 1mg/mL 2 mL;

(I) droperidol 5mg/2mL;

(J) prochlorperazine 10mg/2mL;

(K) promethazine 25mg/mL;

(L) dextrose 25gms/50mL;

(M) glucagon 1mg/mL;

(N) insulin (human) 100 units/mL;

(O) bumetamide 0.5mg/2mL;

(P) furosemide 10mg/mL;

(Q) EMLA Cream 5 gm tube;

(R) Lidocaine 1 percent 30mL vials.

(5) The pharmacy shall ensure that the specific dangerous drugs and quantities to be included in the portable container are listed in the home health agency's or licensed hospice's policies and procedures.

(c) The pharmacy shall not supply a portable container to a home health agency or licensed hospice which does not:

(1) implement and maintain policies and procedures for:

(A) the storage, temperature stability and transportation of the portable container;

(B) the furnishing of dangerous drugs from the portable container upon the written or oral authorization of a prescriber; and

(C) a specific treatment protocol for the administration of each medication contained in the portable container.

(2) have the policies, procedures and protocols reviewed and revised (as needed) annually by a group of professional personnel including a physician and surgeon, a pharmacist and a registered nurse.

(d) A copy of these policies, procedures and protocols shall be maintained by the furnishing pharmacy from each home health agency or licensed hospice for which the pharmacy furnishes portable containers.

(e) In cases where a drug has been administered to a patient pursuant to the oral order of a licensed prescriber, the pharmacy shall ensure that the oral order is immediately written down by the registered nurse or pharmacist and communicated by copy or fax within 24 hours to the furnishing pharmacy, with a copy of the prescriber-signed document forwarded to the dispensing pharmacy within 20 days.

(f) The pharmacy shall ensure that within seven days (168 hours) after the seal has been broken on the portable container, the home health agency's director of nursing service or a registered nurse employed by the home health agency or licensed hospice returns the container to the furnishing pharmacy. The furnishing pharmacy shall then perform an inventory of the drugs used from the container, and if the container will be reused, must restock and reseal the container before it is again furnished to the home health agency or licensed hospice.

(g) The furnishing pharmacy shall have written policies and procedures for the contents, packaging, inventory monitoring, labeling and storage instructions of the portable container. (h) The furnishing pharmacy shall ensure that the home health agency or licensed hospice returns the portable containers to the furnishing pharmacy at least every 60 days for verification of product quality, quantity, integrity and expiration dates, or within seven days (168 hours) after the seal has been broken.

(i) The furnishing pharmacy shall maintain a current inventory and record of all items placed into and furnished from the portable container.

Note: Authority cited: Sections 4005 and 4057, Business and Professions Code. Reference: Sections 4040, 4057, 4081 and 4332, Business and Professions Code.

To Amend § 1751.12 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1754. Obligations of a Pharmacy Furnishing Portable Containers.

(a) A licensed pharmacy shall not issue portable containers to any home health agency or licensed hospice unless the home health agency or licensed hospice complies with provisions of section 1751.11.

(b) A licensed pharmacy shall cease to furnish portable containers to a home health agency or licensed hospice if the home health agency or licensed hospice does not comply with provisions of section 1751.11.

Note: Authority cited: Sections 4005 and 4057, Business and Professions Code. Reference: Sections 4040, 4057, 4081 and 4332, Business and Professions Code.

Attachment 4

Title 16. Board of Pharmacy

Modified Text

Changes made to the originally proposed language are shown by ~~double strike-through~~ for deleted language and double underline for added language. Changes made to the modified proposed language are shown by ~~*strike-through italics*~~ for deleted language and *bold underline italics* for added language. Additionally, the new modified changes have been highlighted in yellow for color printers.

To Amend § 1735 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735. Compounding in Licensed Pharmacies.

(a) "Compounding" means any of the following activities occurring in a licensed pharmacy, by or under the supervision of a licensed pharmacist, pursuant to a prescription:

(1) Altering the dosage form or delivery system of a drug

(2) Altering the strength of a drug

(3) Combining components or active ingredients

(4) Preparing a compounded drug ~~product~~ preparation from chemicals or bulk drug substances

(b) "Compounding" does not include reconstitution of a drug pursuant to a manufacturer's direction(s) for oral, rectal, topical, or injectable administration, nor does it include the sole act of tablet splitting or crushing, capsule opening, or the addition of flavoring agent(s) to enhance palatability.

~~(c) "Compounding" does not include, except in small quantities under limited circumstances as justified by a specific, documented, medical need, preparation of a compounded drug product that is commercially available in the marketplace or that is essentially a copy of a drug product preparation that is commercially available in the marketplace.~~

~~(d)~~(c) The parameters and requirements stated by this Article 4.5 (Section 1735 et seq.) apply to all compounding practices. Additional parameters and requirements applicable solely to sterile ~~injectable~~ compounding are stated by Article 7 (Section 1751 et seq.).

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1735.1 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.1. Compounding Definitions.

(a) "Ante-area" ~~(also called ante-room)~~ means an area providing at least an ISO Class 8 or better air quality ~~area~~ where personnel hand hygiene and garbing procedures, staging of components, and other high-particulate-generating activities are performed, that is adjacent to the area designated for sterile compounding. It is a transition area that begins the systematic reduction of particles, prevents large fluctuations in air temperature and pressures in the buffer area *or* , and maintains air flows from clean to dirty areas.

~~(b) "Batch" means compounding of two or more finished drug preparation units produced during the same continuous cycle of compounding and shall include any multiple dose vials prepared for administration to more than one patient.~~

~~(c)~~(b) "Beyond use date" means the date, or date and time, after which administration of a compounded drug preparation shall not be ~~stored or transported, or administration~~ begun, the preparation shall not be dispensed, and the preparation shall not be stored (other than for quarantine purposes).

(c) "Biological Safety Cabinet (BSC)" means a ventilated cabinet for compounded sterile drug preparations, having an open front with inward airflow for personnel protection, downward ~~high-efficiency particulate absorption (~~HEPA~~)~~-filtered laminar airflow for product protection, and HEPA-filtered exhausted air for environmental protection.

(d) "Buffer area" means an area *which maintains seqregation fron the adjacent ante-area by means of specific pressure differentials. The principle of displacement airflow shall be employed. This concept utilizes a low pressure differential, high airflow principle. Using displacement airflow typically requires an air velocity of 40 ft per minute or more from the buffer area across the line of demarcation into the ante-area. The displacement concept may not be used to maintain buffer area requirements for sterile compounds which originate from any ingredient that was at any time non-sterile, regardless of intervening sterilization of the ingredient, for hazardous compounds, or for chemotherapy compounds.* ~~*providing at least an ISO Class 7 or better air quality where the primary engineering control (PEC) is physically located.*~~

(e) “Bulk drug substance~~s~~” means any substance ~~that is represented for use in a drug and~~ that, when used in the ~~*manufacturing*~~ *preparation* of a compounded drug preparation, processing, or packaging of a drug, becomes an active ingredient or a finished dosage form of the drug, but the term does not include intermediate~~s~~ used in the synthesis of such substances.

(f) “Cleanroom” ~~*(which may also be referred to as a buffer area)*~~ means a *physically* separate room ~~*or area*~~ with ~~*or without*~~ walls and doors that provide~~ing~~ at least an ISO Class 7 or better ~~area~~ *air quality* where the primary engineering control (PEC) is *physically* located. ~~This~~ ~~*The cleanroom may maintains segregation from the adjacent ante-area (ante-room) by means of specific pressure differentials. For cleanrooms providing a physical separation through the use of walls, doors, and pass-throughs, a*~~ *A* minimum differential positive pressure of 0.02- to 0.05-inch water column is required. ~~*For buffer areas not physically separated from the ante-areas, the principle of displacement airflow shall be employed. This concept utilizes a low-pressure differential, high airflow principle. Using displacement airflow typically requires an air velocity of 40 ft per minute or more from the buffer area across the line of demarcation into the ante-area. The displacement concept shall may not be used for high-risk compounding to maintain cleanroom area requirements for sterile compounds which originated with non-sterile-to-sterile batch, with any ingredient that was at any time non-sterile, regardless of intervening sterilization of that ingredient, for hazardous compounds, or for chemotherapy compounds.*~~

(g) “Compounding Aseptic Isolator (CAI)” means a form of isolator specifically designed for compounding pharmaceutical ingredients or preparations. It is designed to maintain an aseptic compounding environment within the isolator throughout the compounding and material transfer processes. Air exchange into the isolator from the surrounding environment should not occur unless the air has first passed through a microbial retentive filter (HEPA minimum) system capable of containing airborne concentrations of the physical size and state of the drug being compounded.

(h) “Compounding Aseptic Containment Isolator (CACI)” means a compounding aseptic isolator (CAI) designed to provide worker protection from exposure to undesirable levels of airborne drug throughout the compounding and material transfer processes and to provide an aseptic environment for compounding sterile preparations. Air exchange with the surrounding

environment should not occur unless the air is first passed through a microbial retentive filter (HEPA minimum) system capable of containing airborne concentrations of the physical size and state of the drug being compounded. Where volatile hazardous drugs are prepared, the exhaust air from the isolator should be appropriately removed by properly designed building ventilation.

~~(c)~~(i) "Controlled cold temperature" means 2~~.~~2 degrees to ~~7.7~~ 8 degrees C (~~36~~35.6 degrees to ~~46~~46.4 degrees F) (USPN.F 37-NF-32).

~~(h)~~(j) "Controlled freezer temperature" means -25 degrees to -10 degrees C (-13 degrees to 14 degrees F) *or at a range otherwise specified by the pharmaceutical manufacturer*. ~~*Preparations may be stored at an alternate temperature range in accordance with the manufacturer's recommendations or literature.*~~

~~(i)~~(k) "Controlled room temperature" means 20 degrees to 25 degrees C (68 degrees to 77 degrees F).

(l) "Copy or essentially a copy" of a commercially available drug product includes all preparations that are comparable in active ingredients to commercially available drug products, except that it does not include any preparations in which there has been a change, made for an identified individual patient, which produces for that patient a significant difference, as determined by a prescribing practitioner, between that compounded preparation and the comparable commercially available drug product.

~~(j)~~(m) "Daily" means occurring every day that a pharmacy is operating.

(n) "Dosage unit" means a quantity sufficient for one administration to one patient, except that for self-administered ophthalmic drops, a quantity sufficient for 30 days or less shall be considered one dosage unit.

~~(a)~~ ~~(j)~~(o) "Equipment" means items that must be calibrated, maintained or periodically certified.

~~(k)~~(p) "First air" means the air exiting the HEPA filter in a unidirectional air stream that is essentially particle free.

~~(l)~~(q) "Gloved fingertip sampling" means a process where~~by,~~ compounding personnel lightly press each fingertip and thumb onto appropriate growth media, which ~~that~~ are then

incubated at a temperature and for a time period conducive to multiplication of microorganisms, and then examined for growth of microorganisms.

(r) "Hazardous" means all anti-neoplastic agents ~~as~~ identified by the National Institute for Occupational Safety and Health (NIOSH) *as meeting the criteria for a hazardous drug* and any other drugs, compounds, or materials identified as hazardous by the pharmacist-in-charge.

~~(b)~~~~(m)~~(s) "Integrity" means retention of potency ~~that all aspects of quality including sterility, packaging, chemical stability and potency, handling, and transport and storage are maintained throughout the drug preparation process, and~~ until the ~~expiration~~ beyond use date ~~noted~~ provided on the label, so long as the preparation is stored and handled according to the label directions after it is dispensed.

(t) "Lot" means one or more compounded drug preparation(s) prepared during one uninterrupted continuous cycle of compounding from one or more common active ingredient(s).

~~(n)~~(u) "Media-fill test" means a test that mimics compounding procedures using a growth-based media to demonstrate that aseptic techniques of compounding personnel or processes routinely employed do not result in microbial contamination. To be valid, media-fill tests ~~are~~ must be conducted on both the most routine and the most challenging ~~and routine~~ compounding procedures performed.

(v) "Non-sterile-to-sterile batch" means any compounded drug preparation containing ~~one (1)~~*two (2)* or more dosage units with any ingredient that was at any time non-sterile, regardless of intervening sterilization of that ingredient.

~~(o)~~(w) "Parenteral" means a ~~sterile~~ preparation of drugs ~~for injection or implantation through one or more layers of skin~~ administered in a manner other than through the digestive tract. This includes, but is not limited to, injection through one or more layers of skin, administration into the eye, and by inhalation.

~~(p)~~(x) "Personal protective equipment" means clothing or devices that protect the employee from exposure to drug products and minimize the contamination of compounded preparations. These include shoe covers, head and facial hair covers, face masks, gowns, and gloves.

~~(c)~~~~(q)~~(y) "Potency" means active ingredient strength within +/- 10% (or the range specified

in USP37-NF32, 37th Revision, Through 2nd Supplement Effective December 1, 2014) of the labeled amount.

~~(r)~~(z) "Preparation" means a drug or nutrient compounded in a licensed pharmacy; the preparation may or may not be ~~contain~~ sterile ~~products~~.

~~(s)~~(aa) "Prescriber's office" or "prescriber office" means an office or suite of offices in which a prescriber regularly sees patients for outpatient diagnosis and treatment. This definition does not include any hospital, pharmacy, or other facility, whether or not separately licensed, that may be affiliated with, adjacent to, or co-owned by, the prescriber's practice environment.

~~(t)~~(ab) "Primary Engineering Control (PEC)" means a device that provides an ISO Class 5 or better environment ~~or better~~ through the use of unidirectional HEPA-filtered first air for the exposure of critical sites when compounding sterile preparations. Examples of PEC devices include, but are not limited to, laminar airflow workbenches, biological safety cabinets, compounding aseptic isolators, and compounding aseptic containment isolators.

~~(u)~~(ac) "Process validation" means demonstrating that when a process is ~~operated~~ *repeated* within specified limits, the process will consistently produce preparations complying with predetermined requirements. If any aspect of the process is changed, the process would need to be revalidated.

~~(v)~~(ad) "Product" means a commercially manufactured drug or nutrient ~~that has been~~ evaluated for safety and efficacy by the FDA.

~~(d)~~~~(w)~~(ae) "Quality" means the absence of harmful levels of contaminants, including filth, putrid, or decomposed substances, ~~and~~ the absence of active ingredients other than those listed on the label, and the absence of inactive ingredients other than those listed ~~noted~~ on the ~~*compounding log*~~*master formula record* ~~label~~.

~~(x)~~(af) "Segregated sterile compounding area" means a designated space for sterile-*to-sterile* compounding where a ~~device that provides unidirectional airflow of ISO Class 5 air quality, including compounding aseptic isolators,~~ PEC is located within either a demarcated area (at least three foot perimeter) or in a separate room. Such area or room shall not contain and shall be void of activities and materials that are extraneous to sterile compounding. The

segregated sterile compounding area shall not be in a location that has unsealed windows or doors that connect to the outdoors, in a location with high traffic flow, or in a location that is adjacent to construction sites, warehouses, or food preparation. ~~, and~~ *The segregated sterile compounding area* shall not have a sink*, other than an emergency eye-washing station,* located within ~~*at least*~~ three feet of the a PEC. ~~This~~ The segregated sterile compounding area ~~will~~ shall be restricted to preparing non-hazardous sterile-to-sterile compounded preparations.

~~(y) "Smoke test" means an analysis of the airflow in the ISO Class 5 PEC using a smoke-generating device.~~

~~(e)~~~~(z)~~(ag) "Strength" means amount of active ingredient per ~~*dosage*~~ unit of a compounded drug ~~product~~ preparation.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1735.2 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.2. Compounding Limitations and Requirements; Self-Assessment.

(a) Except as specified in (b) and (c), no drug ~~product~~ preparation shall be compounded prior to receipt by a pharmacy of a valid prescription for an individual patient where the prescriber has approved use of a compounded drug ~~product~~ preparation either orally or in writing. Where approval is given orally, that approval shall be noted on the prescription prior to compounding.

(b) A pharmacy may prepare and store a limited quantity of a compounded drug ~~product~~ preparation in advance of receipt of a patient-specific prescription where and solely in such quantity as is necessary to ensure continuity of care for an identified population of patients of the pharmacy based on a documented history of prescriptions for that patient population.

(c) A "reasonable quantity" ~~as used in~~ that may be furnished to a prescriber for office use by the prescriber as authorized by Business and Professions Code section 4052, subdivision (a)(1), means that amount of compounded drug ~~product~~ preparation that:

(1) ~~*i*~~*I*s ordered by the prescriber or the prescriber's agent and paid for by the prescriber at a price that fairly reflects the fair market value of each drug preparation, using a purchase order or

other documentation received by the pharmacy prior to furnishing that lists the number of patients seen or to be seen in the prescriber's office for whom the drug is needed or anticipated, and the quantity for each patient that is sufficient for either office administration ~~or application to patients in the prescriber's office, or for distribution of not more than~~ or furnishing of a 72-hour supply ~~to the prescriber's patients, as estimated by the prescriber~~; and

(2) ~~i~~*I*s delivered to the prescriber's office and signed for by the prescriber or the prescriber's agent; and

(3) ~~i~~*I*s sufficient for administration or application to patients solely in the prescriber's office, or for furnishing of not more than a 72-hour supply *for human medical practices, or a 120-hour supply for veterinary medical practices,* solely to the prescriber's own patients seen as part of regular treatment in the prescriber's office, as fairly estimated by the prescriber and documented on the purchase order or other documentation submitted to the pharmacy prior to furnishing; and

(4) That the pharmacist has a credible basis for concluding is reasonable considering the intended use of the compounded medication and the nature of the prescriber's practice; and

~~(3)~~ (5) ~~for~~ With regard to any individual prescriber to whom the pharmacy furnishes, and with regard to ~~for~~ all prescribers to whom the pharmacy furnishes, ~~taken as a whole~~, is an amount which the pharmacy is capable of compounding in compliance with pharmaceutical standards for integrity, potency, quality and strength of the compounded drug ~~product~~ preparation; and

(6) does not exceed an amount the pharmacy can reasonably and safely compound.

(d) No pharmacy or pharmacist shall compound a drug preparation that:

(1) ~~i~~*I*s classified by the FDA as demonstrably difficult to compound;

(2) ~~a~~*A*ppears on a*n* FDA list of drugs that have been withdrawn or removed from the market because such drugs or components of such drugs have been found to be unsafe or not effective; or

(3) ~~i~~*I*s a copy or essentially a copy of one or more commercially available drug products, unless that drug product appears on an ASHP (American Society of Health-System Pharmacists) or FDA list of drugs that are in short supply at the time of compounding and at the time of dispense, and the compounding of that drug preparation is justified by a specific, documented medical

need made known to the pharmacist prior to compounding. The pharmacy shall retain a copy of the documentation of the shortage and the specific medical need in the pharmacy records for three years from the date of receipt of the documentation.

(~~d~~ e) A drug ~~product~~ preparation shall not be compounded until the pharmacy has first prepared a written master formula record that includes at least the following elements:

(1) Active ingredients to be used.

(2) Equipment to be used.

(3) ~~Expiration dating requirements. The rationale or reference source for determining t~~The maximum allowable beyond use date for ~~this~~ the preparation, and the rationale or reference source justifying its determination.

(4) Inactive ingredients to be used.

(5) ~~Process and/or procedure~~ Specific compounding steps used to prepare the drug.

(6) Quality reviews required at each step in preparation of the drug.

(7) Post-compounding process or procedures required, if any.

(8) Instructions for storage and handling of the compounded drug preparation.

(~~e~~ f) Where a pharmacy does not routinely compound a particular drug ~~product~~ preparation, the master formula record for that ~~product~~ preparation may be recorded on the prescription document itself.

(~~f~~ g) The pharmacist performing or supervising compounding is responsible for the integrity, potency, quality, and labeled strength of a compounded drug ~~product~~ preparation until the beyond use date indicated on the label, so long as label instructions for storage and handling are followed after the preparation is dispensed.

(~~g~~ h) All chemicals, bulk drug substances, drug products, and other components used for drug compounding shall be stored and used according to compendia~~l~~ and other applicable requirements to maintain their integrity, potency, quality, and labeled strength.

(~~h~~ i) Every compounded drug ~~product~~ preparation shall be given a~~n expiration~~ beyond use date representing the date beyond which, in the professional judgment of the pharmacist performing or supervising the compounding, it should not be used, stored, transported, or administration begun. This “beyond use date” of the compounded drug ~~product~~ preparation

shall not exceed ~~180 days from preparation or~~ the shortest expiration date of any component in the compounded drug ~~product~~ preparation, nor shall it exceed 180 days from preparation unless a ~~longer~~ later date is supported by stability studies of finished drugs or compounded drug ~~products~~ preparations using ~~the same~~ *identical* components and packaging. Shorter dating than set forth in this subsection may be used if it is deemed appropriate in the professional judgment of the responsible pharmacist.

(~~i~~ j) The pharmacist performing or supervising compounding is responsible for the proper preparation, labeling, storage, and delivery of the compounded drug ~~product~~ preparation.

~~(j k) Prior to allowing any drug product preparation to be compounded in a pharmacy, the pharmacist-in-charge shall complete a self-assessment for compounding pharmacies developed by the board (Incorporated by reference is "Community Pharmacy & Hospital Outpatient Pharmacy Compounding Self-Assessment" Form 17M-39 Rev. 02/12.) as required by Section 1715 of Title 16, Division 17, of the California Code of Regulations. That form contains a first section applicable to all compounding, and a second section applicable to sterile injectable compounding. The first section must be completed by the pharmacist-in-charge before any compounding is performed in the pharmacy. The second section must be completed by the pharmacist-in-charge before any sterile injectable compounding is performed in the pharmacy. The applicable sections of the self-assessment shall subsequently be completed before July 1 of each odd-numbered year, within 30 days of the start date of a new pharmacist-in-charge or change of location, and within 30 days of the issuance of a new pharmacy license. The primary purpose of the self-assessment is to promote compliance through self-examination and education.~~

~~(l)~~(k) Packages of ingredients, both active and inactive, that lack a supplier's expiration date are subject to the following limitations:

(1) such ingredients cannot be used for any non-sterile compounded drug preparation more than three (3) years after the date of receipt by the pharmacy unless either appropriate and documented inspection or analytical testing indicates that the ingredient has retained its purity and quality for use in compounded drug preparations, considering the container in which it is packaged and the storage conditions, and

(2) such ingredients cannot be used for any sterile compounded drug preparation more than one (1) year after the date of receipt by the pharmacy, unless either appropriate and documented inspection or analytical testing indicates that the ingredient has retained its purity and quality for use in compounded drug preparations, considering the container in which it is packaged and the storage conditions.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code, Sections 1735, 1735.1, 1735.8, and 1751.1-1751.8 of Title 16, Division 17, of the California Code of Regulations.

To Amend § 1735.3 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.3. ~~Records~~ Recordkeeping ~~of~~ for Compounded Drug ~~Products~~ Preparations.

(a) For each compounded drug ~~product~~ preparation, ~~the~~ pharmacy records shall include:

(1) The master formula record.

(2) The date the drug ~~product~~ preparation was compounded.

(3) The identity of ~~the~~ any pharmacy personnel ~~who compounded the~~ engaged in compounding the drug ~~product~~ preparation.

(4) The identity of the pharmacist reviewing the final drug ~~product~~ preparation.

(5) The quantity of each component used in compounding the drug ~~product~~ preparation.

(6) The manufacturer, expiration date and lot number of each component. If the manufacturer name is demonstrably unavailable, the name of the supplier may be substituted. If the manufacturer does not supply an expiration date for any component, the records shall include the date of receipt of the component in the pharmacy, and the limitations of section 1735.2, subdivision (k) shall apply. Exempt from the requirements in this paragraph are sterile ~~products~~ preparations compounded ~~on a one- time basis~~ in a single lot for administration within seventy-two (72) hours to an inpatient in a health care facility licensed under section 1250 of the Health and Safety Code and stored in accordance with standards for "Redispensed CSPs" found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP37-NF32)

Through 2nd Supplement (~~35~~ 37th Revision, Effective ~~May~~ December 1, ~~2012~~ 2014), hereby incorporated by reference~~, to an inpatient in a health care facility licensed under section 1250 of the Health and Safety Code~~.

(7) A pharmacy-assigned reference or lot number for the compounded drug ~~product~~ preparation.

(8) The ~~expiration~~ beyond use date or beyond use date and time of the final compounded drug ~~product~~ preparation, *expressed in the compounding record in a standard date and time format ~~(MM/DD/YYYY and HH:MM)~~*.

(9) The final quantity or amount of drug ~~product~~ preparation compounded for dispensing.

~~(10) Storage for the drug preparation.~~

(b) Pharmacies shall maintain records of the proper acquisition, storage, and destruction of chemicals, bulk drug substances, drug products, and components used in compounding.

(c) Active ~~pharmaceutical~~ ingredients shall be obtained from a ~~FDA registered~~ supplier registered with the Food and Drug Administration (FDA). All other ~~C~~chemicals, bulk drug substances, and drug products~~, and components~~ used to compound drug ~~products~~ preparations shall be obtained, whenever possible, from ~~reliable~~ FDA- registered suppliers. The pharmacy shall acquire and retain ~~any available~~ certificates of purity or analysis, either written in English or translated into English, for chemicals~~,~~ *~~and~~* bulk drug substances, *and* drug products~~, and components~~ used in compounding. ~~Certificate s of purity or analysis are not required for drug products that are approved by the Food and Drug Administration.~~ Certificates of purity or analysis are not required for drug products that are approved by the FDA. Any ~~C~~certificates of purity or analysis acquired by the pharmacy ~~are to~~ shall be matched to the corresponding product received.

(d) Pharmacies shall maintain and retain all records required by this article in the pharmacy in a readily retrievable form for at least three years from the date the record was created. If only recorded and stored electronically, on magnetic media, or in any other computerized form, the records shall be maintained as specified by Business and Professions Code section 4070 subsection (c).

Authority cited: Sections 4005, 4127, and 4169, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1735.4 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.4. Labeling of Compounded Drug ~~Products~~ Preparations.

(a) In addition to the labeling information required under Business and Professions Code section 4076, the label of a compounded drug ~~product~~ preparation shall contain the generic or brand name(s) of the principal active ingredient(s).

(b) A statement that the drug has been compounded by the pharmacy shall be included on the container ~~or on the receipt~~ provided to the patient. Exempt from the requirements of this paragraph are those sterile drug preparations compounded within a health care facility solely for administration, by a licensed health care professional, to *~~an in~~*patient *~~in~~* of the facility. To be treated as such, the "health care facility" must be licensed under Health and Safety Code section 1250.

(c) Drug ~~products~~ preparations compounded into unit-dose containers that are too small or otherwise impractical for full compliance with subdivisions (a) and (b) shall be labeled with at least the name of the compounding pharmacy and dispensing pharmacy, if different, the name(s) of the active ingredient(s), ~~concentration or~~ strength, volume or weight of the preparation, pharmacy reference or lot number, and ~~expiration~~ beyond use date.

Note: Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, 4076 and 4127, Business and Professions Code.

To Amend § 1735.5 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.5. Compounding Policies and Procedures.

(a) Any pharmacy engaged in compounding shall maintain a written policies and procedures manual for compounding that establishes procurement procedures, methodologies for the formulation and compounding of drugs, facilities and equipment cleaning, maintenance, operation, and other standard operating procedures related to compounding. ~~The pharmacy shall follow its policies and procedures~~. Any ~~F~~failure to follow ~~the~~se pharmacy's written policies and procedures shall constitute a basis ~~grounds~~ for disciplinary action.

(b) The policies and procedures manual shall be reviewed and such review shall be documented on an annual basis by the pharmacist-in-charge. The policies and procedures manual ~~and~~ shall be updated whenever changes in policies and procedures ~~processes~~ are implemented.

(c) The policies and procedures manual shall include at least the following:

(1) Procedures for notifying staff assigned to compounding duties of any changes in ~~processes or to the~~ policies or procedures ~~manual~~.

~~*(2) Evidence Documentation demonstrating that staff have been educated and trained on all policies and procedures.*~~

(~~2~~ *3*2) ~~Documentation of a~~ A written plan for recall of a dispensed compounded drug ~~product~~ preparation where subsequent ~~verification~~ information demonstrates the potential for adverse effects with continued use ~~of a compounded drug product~~. The plan shall ensure that ~~A~~all affected doses can be accounted for during ~~as part of~~ the recall.

(~~3~~ *43*) The procedures for maintaining, storing, calibrating, cleaning, and disinfecting equipment used in compounding, and for training on these procedures as part of the staff training and competency evaluation process.

(~~5~~*4*) The procedures for evaluating, maintaining, certifying, cleaning, and disinfecting the facility (physical plant) used for compounding, and for training on these procedures as part of the staff training and competency evaluation process.

(~~4~~*65*) Documentation of the methodology ~~appropriate to compounded drug preparations~~ used to ~~test~~ validate integrity, potency, quality, and labeled strength of compounded drug ~~products~~ preparations. The methodology must be appropriate to compounded drug preparations.

(~~5~~ *76*) Documentation of the methodology and rationale or reference source used to determine appropriate ~~expiration~~ beyond use dates for compounded drug ~~products~~ preparations.

(~~8~~7) ~~Dates of annual reviews of the policy and procedure manual by the pharmacist-in-charge, signed and dated by the pharmacist-in-charge.~~ Dates and signatures reflecting all annual reviews of the policies and procedures manual by the pharmacist-in-charge.

(~~9~~8) Dates and signatures accompanying ~~of~~ any revisions to the policies and procedures manual approved by the pharmacist-in-charge~~, signed and dated by the pharmacist-in-charge.~~

(~~10~~9) Policies and procedures for storage of compounded ~~sterile~~ drug preparations in the pharmacy and daily documentation of all room, refrigerator, and freezer temperatures within the pharmacy.

(~~11~~10) Policies and procedures regarding ensuring appropriate functioning of refrigeration devices, monitoring refrigeration device temperatures, and actions to take regarding any out of range temperature variations within the pharmacy.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, ~~and~~ 4127, and 4301, Business and Professions Code.

To Amend § 1735.6 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.6. Compounding Facilities and Equipment.

(a) Any pharmacy engaged in compounding shall maintain written documentation regarding the facilities and equipment necessary for safe and accurate compounded drug ~~products~~ preparations. This shall include records of maintenance and cleaning of the facilities and equipment. Where applicable, this shall also include records of certification(s) of facilities or equipment.

(b) Any equipment used to compound drug ~~products~~ preparations shall be stored, used, ~~and~~ maintained, and cleaned in accordance with manufacturers' specifications.

(c) Any equipment that weighs, measures, or transfers ingredients used to compound drug ~~products~~ preparations for which calibration or adjustment is appropriate shall be calibrated prior to use, on a schedule and by a method determined by the ~~per~~ manufacturer's

specifications, to ensure accuracy. Documentation of each such calibration shall be recorded ~~in writing~~ in a form which is not alterable and these records of calibration shall be maintained and retained in the pharmacy.

(d) Any pharmacy engaged in any hazardous drug compounding shall maintain written documentation regarding appropriate cleaning of facilities and equipment to prevent cross-contamination with non-hazardous drugs.

Note: Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052 and 4127, Business and Professions Code.

To Amend § 1735.7 in Article 4.5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1735.7. Training of Compounding Staff.

(a) Any pharmacy engaged in compounding shall maintain written documentation sufficient to demonstrate that pharmacy personnel have the skills and training required to properly and accurately perform their assigned responsibilities relating to compounding. *Additionally, documentation demonstrating that staff have been trained on all policies and procedures shall be maintained.*

(b) The pharmacy shall develop and maintain an ongoing competency evaluation process for pharmacy personnel involved in compounding, and shall maintain documentation of any and all training related to compounding undertaken by pharmacy personnel.

(c) Pharmacy personnel assigned to compounding duties shall demonstrate knowledge about processes and procedures used in compounding prior to compounding any drug ~~product~~ preparation.

Note: Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052 and 4127, Business and Professions Code.

To Amend § 1735.8 in Article 4.5 of Division 17 of Title 16 of the California Code of

Regulations to read as follows:

1735.8. Compounding Quality Assurance.

(a) Any pharmacy engaged in compounding shall maintain, as part of its written policies and procedures, a written quality assurance plan designed to monitor and ensure the integrity, potency, quality, and labeled strength of compounded drug ~~products~~ preparations.

(b) The quality assurance plan shall include written procedures for verification, monitoring, and review of the adequacy of the compounding processes and shall also include written documentation of review of those processes by qualified pharmacy personnel.

(c) The quality assurance plan shall include written standards for qualitative and quantitative analysis of compounded drug preparations to ensure integrity, potency, quality, and labeled strength, including the frequency of testing, ~~analysis~~ of compounded drug ~~products~~ preparations. All qualitative and quantitative analysis reports for compounded drug ~~products~~ preparations shall be retained by the pharmacy and ~~collated~~ maintained along with the compounding record and master formula. The quality assurance plan shall include a schedule for routine testing and analysis of compounded drug preparations to ensure integrity, potency, quality, and labeled strength, on at least an annual basis.

(d) The quality assurance plan shall include a written procedure for scheduled action in the event any compounded drug ~~product~~ preparation is ever discovered to be below minimum standards for integrity, potency, quality, or labeled strength.

(e) The quality assurance plan shall include a written procedure for responding to out-of-range temperature variations within the pharmacy or within patient care areas of a hospital where a furnished drug is returned for redispensing. ~~including for preparations furnished to patient care areas.~~

Note: Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052 and 4127, Business and Professions Code.

To Amend § 1751 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

Article 7. Sterile ~~Injectable~~ Compounding

1751. Sterile ~~Injectable~~ Compounding; Compounding Area; Self-Assessment.

(a) Any pharmacy engaged in compounding sterile ~~injectable~~ drug ~~products~~ preparations shall conform to the parameters and requirements stated by Article 4.5 (Section 1735 et seq.), applicable to all compounding, and shall also conform to the parameters and requirements stated by this Article 7 (Section 1751 et seq.), applicable solely to sterile ~~injectable~~ compounding.

(b) Any pharmacy compounding sterile ~~injectable~~ drug ~~products~~ preparations shall have a ~~designated~~ compounding area designated for the preparation of sterile ~~injectable~~ drug ~~products~~ preparations that is in a restricted location where traffic has no impact on the performance of the PEC(s). The buffer area *or cleanroom*, including the walls, ceilings, and floors, shall be constructed in accordance with Section 1250.4 of Title 24, Part 2, Chapter 12, of the California Code of Regulations. The pharmacy shall be ventilated in a manner in accordance with Section 505.~~12~~*125* of Title 24, Part 4, Chapter 5 of the California Code of Regulations. ~~which shall meet the following standards:~~ The environments within the pharmacy shall meet the following standards:

(1) ~~Clean Room and Work Station Requirements, shall be in accordance with Section 1250 of Title 24, Part 2, Chapter 12, of the California Code of Regulations.~~

~~(2) Walls, ceilings and floors shall be constructed in accordance with Section 1250 of Title 24, Part 2, Chapter 12, of the California Code of Regulations.~~

~~(3) Be ventilated in a manner in accordance with Section 505.12 of Title 24, Chapter 5 of the California Code of Regulations.~~

~~(4) Be~~ Each ISO environment shall be certified ~~annually~~ at least every six months by a qualified technician ~~who is familiar with the methods and procedures for certifying laminar air flow hoods and clean room requirements, in accordance with standards adopted by the United States General Services Administration~~ *in accordance with Section 1751.4* ~~of Title 16, Division~~

~~17, of the California Code of Regulations~~. Certification records must be retained ~~*for* at least 3 years~~ in the pharmacy.

~~(5)~~ (2) ~~The pharmacy shall be arranged in accordance with Section 1250 of Title 24, Part 2, Chapter 12, of the California Code of Regulations.~~ Items related to the compounding of sterile ~~injectable~~ drug ~~products~~ preparations within the compounding area shall be stored in such a way as to maintain the integrity of an aseptic environment.

~~(6)~~ (3) A sink shall be included in accordance with Section 1250.4 of Title 24, Part 2, *Chapter 12*, of the California Code of Regulations. Sinks and drains shall not be present in ~~an~~ any ISO Class 7 or better buffer area *or cleanroom*, nor in a segregated sterile compounding area within three feet of an ISO Class 5 or better PEC ~~or better located in segregated compounding areas~~, with the exception of emergency eye-rinsing stations. A sink may be located in an ante-area.

~~(7)~~ (4)There shall be a refrigerator and, ~~/or~~ where appropriate, a freezer, of sufficient capacity to meet the storage requirements for all material requiring refrigeration or freezing, and a backup plan to ensure continuity of available compounded drug preparations in the event of a power outage.

~~(c) Any pharmacy compounding a sterile injectable drug product preparation from one or more non-sterile ingredients shall comply with Business and Professions Code section 4127.7.~~

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127 ~~and 4127.7~~, Business and Professions Code; Sections 1735, 1735.1,-1735.8., and 1751.1-1751.8. of Title 16, Division 17, of the California Code of Regulations; and Section 18944, Health and Safety Code.

To Amend § 1751.1 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.1. Sterile ~~Injectable~~ Compounding Recordkeeping Requirements.

(a) ~~Pharmacies compounding sterile injectable products for future use pursuant to section 1735.2 shall, in addition to those records required by section 1735.3, make and keep records~~

~~indicating the name, lot number, amount, and date on which the products were provided to a prescriber.~~

~~(b)~~ In addition to the records required by section 1735.3 ~~and subdivision (a)~~, any pharmacy engaged in any compounding of ~~for~~ sterile ~~compounded~~ drug ~~products~~ preparations ~~compounded from one or more non-sterile ingredients~~, shall make and keep the following records ~~must be made and kept by~~ within the pharmacy:

(1) Documents evidencing ~~The~~ training and competency evaluations of employees in sterile ~~product~~ drug preparation policies and procedures.

(2) Results of hand hygiene and garbing assessments with integrated gloved fingertip testing.

(3) Results of assessments of personnel for aseptic techniques including results of media-fill tests and gloved fingertip testing performed in association with media-fill test~~s~~~~ing~~.

(4) Results of viable volumetric air and surface sampling.

~~(2)~~ (5) Documents indicating ~~D~~daily recordation ~~documentation~~ of room, ~~R~~ refrigerator, and freezer temperatures appropriate for sterile compounded drug preparations consistent with the temperatures listed in section 1735.1 for:~~:~~

(A) Controlled room temperature.

(B) Controlled cold temperature.

(C) Controlled freezer temperature.

~~(3)~~ (6) Certification(s) of the sterile compounding environment(s).

(7) Documents indicating ~~D~~daily recordation ~~documentation~~ of air pressure differentials or air velocity measurements between all adjoining ~~all~~ ISO rooms or areas ~~and measurement between all ISO rooms or areas~~, including those associated with compounding aseptic (containment) isolators, and air pressure differentials or air velocity measurements between all rooms or spaces with an immediate entry or opening to ISO rooms or areas.

~~(4)~~ (8) Other facility quality control ~~logs~~ records specific to the pharmacy's policies and procedures (e.g., cleaning logs for facilities and equipment).

~~(5)~~ (9) Logs or other documentation of ~~i~~inspections for expired or recalled ~~pharmaceutical products or raw ingredients~~ chemicals, bulk drug substances, drug products, or other ingredients.

~~(6)~~ (10) Preparation records including the master work sheet, the preparation work sheet, and records of end-product evaluation results.

(b) Pharmacies compounding sterile drug preparations for future use pursuant to section 1735.2 shall, in addition to those records required by section 1735.3, make and keep records indicating the name ~~of the compounded drug preparation~~, lot number, and amount of any drug preparation compounded for future use, ~~and~~ the date on which ~~*the*~~*any* preparation was provided to a prescriber, and the name, address, and license number of the prescriber.

(c) Pharmacies shall maintain and retain all records required by this article in the pharmacy in a readily retrievable form for at least three years from the date the record was created. If only recorded and stored electronically, on magnetic media, or in any other computerized form, the records shall be maintained as specified by Business and Professions Code section 4070 subsection (c).

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.2 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.2. Sterile ~~Injectable~~ Compounding Labeling Requirements.

In addition to the labeling information required under Business and Professions Code section 4076 and California Code of Regulations section 1735.4, a pharmacy ~~which~~ that compounds sterile ~~injectable~~ drug ~~products~~ preparations shall include the following information on the label~~s~~ for each such ~~those~~ ~~products~~ preparation:

(a) The ~~T~~telephone number ~~*is not required on the label*~~ of the pharmacy. ~~, except~~ The telephone number is not required on the label for sterile ~~injectable~~ drug ~~products~~ preparations dispensed ~~for~~ to ~~*in*~~patients ~~of~~ ~~___~~ *within the* hospital ~~*pharmacy*~~.

(b) Name and ~~*concentrations*~~ *strength, volume, or weight* of each ingredient~~s~~ contained in the sterile ~~injectable~~ drug ~~product~~

preparation.

(c) Instructions for storage and handling.

(d) All ~~cytotoxic~~ hazardous agents shall bear a special label which states ~~"Chemotherapy - Dispose of Properly" or~~ "~~Cytotoxic~~ Hazardous – Dispose of Properly~~.~~" or "Chemotherapy - Dispose of Properly~~,~~" ~~*if applicable*~~.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, 4076 and 4127, Business and Professions Code.

To Amend § 1751.3 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.3. Sterile ~~Injectable~~ Compounding Policies and Procedures.

(a) Any pharmacy engaged in compounding sterile ~~injectable~~ drug ~~products~~ preparations shall maintain a written policies and procedures manual for compounding that includes, in addition to the elements required by section 1735.5, written policies and procedures regarding the following:

~~(1) Compounding, filling, and labeling of sterile injectable compounds drug preparations.~~

~~(2) Labeling of the sterile injectable drug product preparations based on the intended route of administration and recommended rate of administration.~~

~~(3) Proper use of Equipment and supplies.~~

~~(4) Training of staff in all aspects of the preparation of sterile injectable drug products preparations including didactic training and knowledge/competency assessments that include at minimum: hand hygiene and garbing; cleaning and disinfection of controlled compounding areas and proper aseptic technique.~~

~~(5) Hand hygiene and garbing.~~

~~(6) Cleaning and maintenance of ISO environments and segregated compounding areas.~~

~~(7) An environmental sampling plan and procedures specific to viable air, surface and gloved fingertip sampling as well as nonviable particle sampling.~~

~~(8) For compounding aseptic isolators and compounding aseptic containment isolators, documentation of the manufacturer's recommended purge time.~~

~~(9) Media fill testing procedure.~~

~~(10) Compounded sterile drug preparation stability and beyond use dating.~~

~~(11) Visual inspection and other final quality checks of sterile drug preparations.~~

~~(5) (12) Procedures for handling, compounding and disposal of cytotoxic hazardous agents.~~

~~(6) (13) Quality assurance program.~~

~~(7) (14) Record keeping requirements.~~

~~(b) The ingredients and the compounding process for each preparation must be determined in writing before compounding begins and must be reviewed by a pharmacist.~~

~~(c) Pharmacies compounding sterile injectable drug products preparations shall have written policies and procedures for the disposal of infectious materials and/or materials containing cytotoxic hazardous residues. The written policies and procedures shall describe the pharmacy protocols for cleanups and spills in conformity with local health jurisdiction standards.~~

~~(d) Pharmacies compounding sterile injectable drug products preparations from one or more non-sterile ingredients must have written policies and procedures that comply with the following:~~

~~(1) All written policies and procedures shall be immediately available to all personnel involved in these activities and board inspectors.~~

~~(2) All personnel involved must read the policies and procedures before compounding sterile injectable drug products preparations, and any additions, revisions, and deletions to the written policies and procedures must be communicated to all personnel involved in sterile compounding.~~

~~(3) Policies and procedures must address at least the following:~~

~~(A) Orientation, training, and Ccompetency evaluation of compounding personnel.~~

~~(B) Storage and handling of products and supplies.~~

~~(C) Storage and delivery of final products.~~

~~(D) Media fill testing and Pprocess validation.~~

~~(E) Personnel access and movement of materials into and near the controlled area Conduct of~~

~~personnel in controlled areas and aseptic technique overview.~~

~~(F) Use and maintenance of environmental control devices PECs used to create the critical direct compounding area for manipulation of sterile products compounding of sterile drug preparations (e.g., laminar airflow workstations, biological safety cabinets, class 100 cleanrooms, and barrier isolator workstations).~~

~~(G) Regular Daily and monthly cleaning and disinfection schedule for the controlled areas and any equipment in the controlled area and the alternation of disinfectants as specified in California Code of Regulations section 1751.4. Pharmacies subject to an institutional infection control policy may follow that policy as it relates to cleaning schedules and the alternation of disinfectants in lieu of complying with this subdivision.~~

~~(H) Disposal of packaging materials, used syringes, containers, and needles to enhance sanitation and avoid accumulation in the controlled area. Non-viable particle testing.~~

~~(I) For sterile batch compounding, written policies and procedures must be established for the use of master formulas and work sheets and for appropriate documentation. Viable air sampling.~~

~~(J) Sterilization. Surface sampling.~~

~~(K) End-product evaluation and testing. Airflow considerations and pressure differential monitoring.~~

~~(L) Temperature and humidity monitoring in compounding and controlled storage areas.~~

~~(M) Facility management including certification and prevention preventative maintenance of controlled environments and related equipment.~~

~~(N) Gloved fingertip sampling.~~

~~(O) Compounded sterile product stability and assignment of beyond use dating.~~

~~(P) Use of automated compounding devices (if applicable).~~

~~(Q) Hazardous drug compounding (if applicable).~~

~~(i) Hazardous drug employee training and safety program.~~

~~(ii) Hazardous drug handling, storage, labeling and transport.~~

~~(iii) Hazardous drug compounding techniques.~~

~~(iv) Hazardous drug spill, deactivation and waste management.~~

~~(R) Preparing sterile solutions from nonsterile components (if applicable).~~

~~(S) Hand hygiene and garbing.~~

~~(4) Pharmacies subject to an institutional infection control policy may follow that policy as it relates to cleaning schedules and the alternation of disinfectants in lieu of complying with this subparagraph.~~

~~(A) Disposal of packaging materials, used syringes, containers, and needles to enhance sanitation and avoid accumulation in the controlled area.~~

~~(B) For sterile batch compounding:~~

~~(i) use of master formulas and compounding work sheets;~~

~~(ii) appropriate documentation; and~~

~~(iii) appropriate sterility and bacterial endotoxin testing.~~

~~(C) For non-sterile to sterile compounding:~~

~~(i) Sterilization methods~~

~~(ii) End-product evaluation and testing.~~

~~(D) Action levels for colony-forming units (CFUs) detected during viable surface testing, glove-fingertip and volumetric air sampling.~~

(1) Compounding, filling, and labeling of sterile drug preparations.

(2) Labeling of ~~*the*~~ sterile *compounded* drug preparations based on the intended route of administration and recommended rate of administration.

(3) Proper use of equipment and supplies.

(4) Hand hygiene and garbing.

(5) Media-fill testing procedure.

(6) Quality assurance program.

(7) Record keeping requirements.

(8) Compounded sterile drug preparation stability and beyond use dating.

(9) Visual inspection and other final quality checks of sterile drug preparations.

(10) Use of automated compounding devices (if applicable).

(11) Preparing sterile ~~*solutions*~~ *compounded drug preparations* from non-sterile components (if applicable).

(12) Orientation, training, and competency evaluation of staff in all aspects of the preparation of sterile drug preparations including didactic training and knowledge/competency assessments that include at minimum: hand hygiene and garbing; decontamination (where applicable); cleaning and disinfection of controlled compounding areas; and proper aseptic technique.

(13) Airflow considerations and pressure differential monitoring.

(14) Cleaning and maintenance of ISO environments and segregated compounding areas.

(15) An environmental sampling plan and procedures specific to viable air, surface and gloved fingertip sampling as well as nonviable particle sampling.

(16) For compounding aseptic isolators and compounding aseptic containment isolators, documentation of the manufacturer's recommended purge time.

(17) Temperature monitoring in compounding and controlled storage areas.

(18) Facility management including certification and maintenance of controlled environments and related equipment.

(19) Action levels for colony-forming units (CFUs) detected during viable surface testing, glove fingertip and volumetric air sampling.

(20) The determination and approval by a pharmacist of ingredients and the compounding process for each preparation before compounding begins.

(21) Procedures for handling, compounding and disposal of hazardous agents. The written policies and procedures shall describe the pharmacy protocols for cleanups and spills in conformity with local health jurisdiction standards.

(22) Procedures for handling, compounding and disposal of infectious materials. The written policies and procedures shall describe the pharmacy protocols for cleanups and spills in conformity with local health jurisdiction standards.

(23) Daily and monthly cleaning and disinfection schedule for the controlled areas and any equipment in the controlled area as specified in section 1751.4.

(b) For lot compounding, the pharmacy shall maintain a written policies and procedures manual that includes, in addition to the elements required by section 1735.5 and 1751.3(a), written policies and procedures regarding the following:

(1) Use of master formulas and compounding work sheets

(2) Appropriate documentation

(3) Appropriate sterility and potency testing.

(c) For non-sterile-to-sterile batch compounding, the pharmacy shall maintain a written policies and procedures manual for compounding that includes, in addition to the elements required by section 1735.5 and 1751.3(a), written policies and procedures regarding the following:

(1) Sterilization methods

(2) End-product evaluation and testing

(d) All written policies and procedures manuals and materials shall be immediately available to all personnel involved in compounding activities and to board inspectors.

(e) All personnel involved must read the policies and procedures before compounding sterile drug preparations, and any additions, revisions, and deletions to the written policies and procedures must be communicated to all personnel involved in sterile compounding. This review must be documented by a signature and date.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.4 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.4. Facility and Equipment Standards for Sterile ~~Injectable~~ Compounding.

(a) No sterile ~~injectable~~ drug ~~product~~ preparation shall be compounded if it is known, or reasonably should be known, that the compounding environment fails to meet criteria specified in the pharmacy's written policies and procedures for the safe compounding of sterile ~~injectable~~ drug ~~products~~ preparations.

(b) During the compounding of ~~preparation of~~ sterile ~~injectable~~ drug ~~products~~ preparations, access to the areas designated ~~area or cleanroom~~ for compounding must be limited to those individuals who are properly attired.

(c) All equipment used in the areas designated ~~area or cleanroom~~ for compounding must be

made of a material that can be easily cleaned and disinfected.

(d) Cleaning and disinfecting surfaces in the ISO Class 5 PEC shall occur frequently, including:

(1) at the beginning of each shift;

(2) before and after each ~~batch~~ lot;

(3) after each spill; and

(4) when surface contamination is known or suspected.

~~(d)~~ (e) ~~Exterior workbench surfaces and other hard surfaces in the designated area, such as walls, floors, ceilings, shelves, tables, and stools, must be disinfected weekly and after any unanticipated event that could increase the risk of contamination.~~ Counters, cleanable work surfaces and floors shall be cleaned with a germicidal detergent and water and disinfected with a suitable agent ~~(e.g., sterile isopropyl alcohol)~~ daily. Walls, ceilings, storage shelving, tables and stools shall be cleaned with a germicidal detergent and water and disinfected with a suitable agent ~~(e.g., sterile isopropyl alcohol)~~ monthly. Cleaning and disinfecting shall occur after any unanticipated event that could increase the risk of contamination.

~~(e)~~ (f) Pharmacies preparing sterile compounded preparations require the use of a PEC that provides ISO Class 5 air or better *air quality*. Certification and testing of primary and secondary engineering controls shall be performed no less than every six months and whenever the device or area designated for compounding is relocated, altered or a service to the facility is performed that would impact the device or area. Certification must be completed by a qualified technician who is familiar with certification methods and procedures in accordance with CETA Certification Guide for Sterile Compounding Facilities (CAG-003-2006-11, Revised January 31, 2012). Certification records must be retained for at least 3 years. Compounding aseptic isolators or compounding aseptic containment isolators may be used outside of an ISO Class 7 buffer area *or cleanroom* if the isolator meets the following criteria:

(1) particle counts sampled approximately 6-12 inches upstream of the critical exposure site shall maintain ISO Class 5 levels during compounding operations.

(2) not more than 3520 particles (0.5 um and larger) per cubic meter shall be counted during material transfer, with the particle counter probe located as near to the transfer door as possible without obstructing transfer.

(3) recovery time to achieve ISO Class 5 air quality shall be documented and internal procedures developed to ensure that adequate recovery time is allowed after material transfer before and during compounding operations.

Compounding aseptic isolators or compounding aseptic containment isolators that do not meet the requirements as outlined in this subdivision ~~and~~*or* are not located within an ISO Class 7 buffer area may only be used to compound preparations that meet the criteria specified in accordance with subdivision (d) of Section 1751.8 of Title 16, Division 17, of the California Code of Regulations.

(g) Pharmacies preparing ~~parenteral cytotoxic~~ sterile hazardous agents shall do so in accordance with Section 505.~~12~~5.1 of Title 24, Chapter 5, of the California Code of Regulations, requiring a ~~laminar air flow hood~~ negative pressure PEC. The ~~hood~~ negative pressure PEC must be certified ~~annually~~ every six months by a qualified technician who is familiar with ~~the methods and procedures for certifying laminar air flow hoods and cleanroom requirements, in accordance with National Sanitation Foundation Standard 49 for Class II (Laminar Flow) Biohazard Cabinetry, as revised May, 1983 (available from the National Sanitation Foundation, 3475 Plymouth Road, P.O. Box 1468, Ann Arbor, Michigan 48106, phone number (313) 769-8010) or manufacturer's specifications.~~ CETA Certification Guide for Sterile Compounding Facilities (CAG-003-2006-11, Revised January 31, 2012). ~~Certification records must be retained for at least 3 years.~~ Any drug preparation that is compounded in a ~~*hazardous drug*~~ PEC where hazardous drugs are prepared must be labeled as hazardous, regardless of whether the drug ingredients are considered hazardous.

During the hazardous drug compounding that is performed in a compounding aseptic containment isolator, full hand hygiene and garbing must occur, complete with hair cover, facemask, beard cover (if applicable), ~~polyprophylen~~ polypropylene or low shedding gown that closes in the back, shoe covers, and two layers of gloves *with the outermost glove* ~~*must be sterile and that have been*~~ tested to meet ASTM 6978-05~~ with the outermost glove that contacts the sterile drug preparation~~. Where the documentation provided by CACI manufacturer does not require garbing, only the two glove requirement shall apply.

(h) If a compounding aseptic isolator is certified by the manufacturer to maintain ISO Class 5 air

quality during dynamic operation conditions during compounding as well as during the transfer of ingredients into and out of the compounding aseptic isolator, then it may be placed into a non-ISO classified room. Individuals that use compounding aseptic isolators in this manner must ensure appropriate garbing, which consists of donning sterile gloves over the isolator gloves immediately before non-hazardous compounding. These sterile gloves must be changed by each individual whenever continuous compounding is ceased and before compounding starts again.

(i) Viable surface sampling shall be done at least ~~monthly for low and medium risk level compounding and weekly for high-risk compounding~~ quarterly for all sterile-to-sterile compounding and monthly for all non-sterile-to-sterile compounding. Volumetric air sampling by impaction shall be done at least once every six months ~~for low and medium risk level compounding and weekly for high risk compounding~~. Viable surface and volumetric air sampling shall be performed by a qualified individual who is familiar with the methods and procedures for surface testing and air sampling. Viable air sampling is to be performed under dynamic conditions that simulate actual production. Surface sampling is to be performed under dynamic conditions of actual compounding. When the environmental monitoring action levels are exceeded, the pharmacy shall identify the CFUs at least to the genus level in addition to conducting an investigation. Remediation shall include an immediate investigation of cleaning and compounding operations and facility management.

(j) The pharmacy shall have a comfortable and well-lighted working environment, which includes a room temperature of 20 degrees Celsius (68 degrees Fahrenheit) or cooler to maintain comfortable conditions for compounding personnel when attired in the required compounding garb. ~~Humidity levels should be consistent ASHRAE Standard 55 (30-65% RH).~~

Note: Authority Cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052 and 4127, Business and Professions Code; and Section 18944, Health and Safety Code.

To Amend § 1751.5 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.5. Sterile ~~Injectable~~ Compounding Attire.

~~(a) When preparing cytotoxic agents, gowns and gloves shall be worn.~~

~~(b)~~ (a) When compounding sterile drug ~~products~~ preparations ~~from one or more non-sterile ingredients~~ the following standards must be met:

(1) ~~Cleanroom garb~~ Personal protective equipment consisting of a ~~low~~ non-shedding ~~coverall~~ gown, head cover, face mask, facial hair covers (if applicable), and shoe covers must be worn inside the designated area at all times, unless the compounding aseptic isolator or compounding aseptic containment isolator manufacturer can provide written documentation, based on validated environmental testing, that any component of the personal protective equipment or personnel cleansing ~~are~~*is* not required.

(2) ~~Cleanroom garb~~ Personal protective equipment must be donned and removed ~~outside the designated area~~ in an ante-area or immediately outside the segregated compounding area.

(3) Personnel shall don personal protective equipment in an order that proceeds from those activities considered the dirtiest to those considered the cleanest. The following order is to be followed unless the pharmacy has a procedure in place that documents a method equivalent to or superior to the method described here: The donning of shoe covers or dedicated shoes, head and facial hair covers and face masks shall be followed by the washing of hands and forearms up to the elbows for 30 seconds with soap and water, drying hands, and then the donning of a non-shedding gown.

~~(3)~~ (4) Compounding personnel shall not wear ~~H~~hand, finger, ~~and~~ or wrist jewelry ~~must be eliminated~~. If jewelry cannot be removed then it must be thoroughly cleaned and covered with a sterile glove.

~~(4) Head and facial hair must be kept out of the critical area or be covered.~~

(5) ~~Gloves made of low-shedding materials are required.~~ Sterile gloves that have been tested for compatibility with disinfection with isopropyl alcohol are required. Hand cleansing with a persistently active alcohol-based product followed by the donning of sterile gloves may occur within the ante or buffer area *or cleanroom*. Gloves are to be routinely disinfected with sterile

70 percent isopropyl alcohol before entering or re-entering the PEC and after contact with non-sterile objects. Gloves shall also be routinely inspected for holes, punctures, or tears and replaced immediately if such are detected.

(6) Individuals experiencing rashes, sunburn, weeping sores, conjunctivitis, active respiratory infections, or those wearing cosmetics shall be excluded from the ISO Class 5 and ISO Class 7 compounding areas until their conditions are remedied.

~~(c) The requirements of subdivision (b) do not apply if a barrier isolator is used to compound sterile injectable products from one or more non-sterile ingredients.~~

(b) When preparing hazardous agents, appropriate gowns and personal protective equipment shall be worn regardless of the PECs used (e.g., biological safety cabinet and compounding aseptic containment isolator).

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.6 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.6 ~~Training of Sterile Injectable Compounding Staff, Patient, and Caregiver.~~ Sterile Compounding Consultation; Training of Sterile Compounding Staff.

(a) Consultation shall be available to the patient and/or primary caregiver concerning proper use, storage, handling, and disposal of sterile ~~injectable~~ drug ~~products~~ preparations and related supplies furnished by the pharmacy.

(b) The pharmacist-in-charge shall ~~be responsible to~~ ensure that all pharmacy personnel engaging in compounding sterile ~~injectable~~ drug ~~products~~ preparations ~~shall~~ have training and demonstrated competence in the safe handling and compounding of sterile ~~injectable~~ drug ~~products~~ preparations, including ~~cytotoxic~~ hazardous agents if the pharmacy compounds products with ~~cytotoxic~~ hazardous agents.

(c) Records of training and demonstrated competence shall be available for each individual and

shall be retained for three years beyond the period of employment.

(d) The pharmacist-in-charge shall be responsible to ensure the continuing competence of pharmacy personnel engaged in compounding sterile ~~injectable~~ drug ~~products~~ preparations.

(e) Pharmacies that compound sterile *drug* ~~products from one or more non-sterile ingredients~~ preparations must comply with the following training requirements:

(1) The pharmacy must establish and follow a written program of training and performance evaluation designed to ensure that each person working in the designated area has the knowledge and skills necessary to perform their assigned tasks properly. This program of training and performance evaluation must address at least the following:

(A) Aseptic technique.

(B) Pharmaceutical calculations and terminology.

(C) Sterile ~~product~~ preparation compounding documentation.

(D) Quality assurance procedures.

(E) Aseptic preparation procedures using media fill tests which are as complicated as the most complex manipulations performed by staff and which contain the same amount or greater of volume transferred during the selected manipulations.

(F) Proper hand hygiene, gowning and gloving technique.

(G) General conduct in the controlled area.

(H) Cleaning, sanitizing, and maintaining of the equipment and ~~used in~~ the controlled area.

(I) Sterilization techniques for compounding sterile drug preparations from one or more non-sterile ingredients.

(J) Container, equipment, and closure system selection.

(2) Each person ~~assigned to the controlled area~~ engaged in sterile compounding must successfully complete practical skills training in aseptic technique and aseptic area practices. Evaluation must include written testing and a written protocol of periodic routine performance checks involving adherence to aseptic area policies and procedures. Each person's proficiency and continuing training needs must be reassessed at least every 12 months. Results of these assessments must be documented and retained in the pharmacy for three years.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.7 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.7. Sterile ~~Injectable~~ Compounding Quality Assurance and Process Validation.

(a) Any pharmacy engaged in compounding sterile ~~injectable~~ drug ~~products~~ preparations shall maintain, as part of its written policies and procedures, a written quality assurance plan including, in addition to the elements required by section 1735.8, a documented, ongoing quality assurance program that monitors personnel performance, equipment, and facilities. The end product shall be examined on a periodic sampling basis as determined by the pharmacist-in-charge to assure that it meets required specifications. The ~~Q~~quality ~~A~~assurance ~~P~~program shall include at least the following:

(1) Procedures for ~~C~~cleaning and sanitization of the ~~parenteral~~ ~~medication~~ sterile preparation area.

~~(2) The storage of compounded sterile injectable products in the pharmacy and periodic documentation of refrigerator temperature.~~

~~(3)~~ (2) Actions to be taken in the event of a drug recall.

~~(4)~~ (3) ~~Written justification of~~ Documentation justifying the chosen ~~expiration~~ beyond use dates for compounded sterile ~~injectable~~ drug ~~products~~ preparations.

(b) Each individual involved in the preparation of sterile ~~injectable~~ drug ~~products~~ preparations must first successfully demonstrate competency by successfully performing aseptic media fill tests ~~complete a validation process on technique~~ before being allowed to prepare sterile ~~injectable~~ drug ~~products~~ preparations. ~~The validation process shall be carried out in the same manner as normal production, except that an appropriate microbiological growth medium is used in place of the actual product used during sterile preparation. The validation process shall be representative of all types of manipulations, products and batch sizes the individual is expected to prepare.~~ The media fill testing process shall be as complicated as the most

complex manipulations performed by staff and contain the same amount or greater of volume transferred during the compounding process. The same personnel, procedures, equipment, and materials must be involved. Media used must have demonstrated the ability to support and promote~~d~~ growth. Completed ~~medium~~ media samples must be incubated in a manner consistent with the manufacturer's recommendations. If microbial growth is detected, then the employee's sterile preparation process must be evaluated, corrective action taken and documented, and the ~~validation process~~ media fill testing repeated. Personnel competency must be revalidated at least every twelve months for sterile to sterile compounding and at least every six months for individuals compounding sterile products from non-sterile ingredients. Aseptic work practice assessments via media fill tests must be revalidated, as appropriate to the circumstance ~~and~~ or personnel found to be deficient, whenever the quality assurance program yields an unacceptable result, when the compounding process changes, equipment used in the compounding of sterile ~~injectable~~ drug ~~products~~ preparations is ~~are repaired or~~ replaced, the facility is modified in a manner that affects airflow or traffic patterns, or whenever improper aseptic techniques are observed. Revalidation must be documented.

(c) All sterile compounding personnel must successfully complete an initial competency evaluation. In addition, immediately following the initial hand hygiene and garbing procedure, all compounding personnel must successfully complete a gloved fingertip sampling procedure (zero colony forming units for both hands) at least three times before initially being allowed to compound sterile drug preparations.

(d) Re-evaluation of garbing and gloving competency shall occur at least every 12 months for personnel compounding products made from sterile ingredients and at least every six months for personnel compounding products from non-sterile ingredients.

~~(c)~~ (e) ~~Batch-produced sterile injectable drug products preparations compounded from one or more non-sterile ingredients~~ Non-sterile-to-sterile ~~batch~~ drug preparations shall be subject to documented end product testing for sterility and pyrogens ~~that are exposed longer than 12 hours at 2 to 8 degrees C and longer than 6 hours at warmer than 8 degrees C before they are sterilized shall meet the sterility test in accordance with methodologies and processes found in Chapter 71 of the United States Pharmacopeia—National Formulary (USP37-NF32) Through~~

~~2nd Supplement (37th Revision, Effective December 1, 2014), and testing for pyrogens in accordance with the methods of Chapters 85 and 151 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference,~~ and shall be quarantined until the end product testing confirms sterility and acceptable levels of pyrogens, per USP chapter 85 limits, before dispensing. This requirement of end product testing confirming sterility and acceptable levels of pyrogens prior to dispensing shall apply regardless of any sterility or pyrogen testing that may have been conducted on any ingredient or combination of ingredients that were previously non-sterile.

~~In a circumstance where a batch-produced sterile drug preparation compounded from one or more non-sterile ingredients is necessary for immediate dispensing where failure to dispense could result in loss of life or intense suffering, the drug preparation may be dispensed before receipt of test results so long as the pharmacy complies with a written procedure included in the pharmacy's policies and procedures that includes:~~

~~(1) Prior to dispensing:~~

~~(A) Notifying the prescriber of the inability to conduct testing;~~

~~(B) Suggesting an available alternative product to the prescriber; and~~

~~(C) Securing the prescriber's written consent to dispense.~~

~~(2) And subsequent to dispensing:~~

~~(A) Daily observation of the incubating test specimens; and~~

~~(B) Immediate recall of the dispensed compounded sterile preparation's when there is any evidence of microbial or pyrogen growth in the test specimens.~~

~~Any such dispensing shall be only in such quantity as is necessary to meet the immediate need and the circumstance causing the immediate need shall be documented in accordance with policies and procedures.~~

~~(d) Batch-produced sterile to sterile transfers shall be subject to periodic testing through process validation for sterility as determined by the pharmacist-in-charge and described in the written policies and procedures.~~

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.8 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.8. Beyond Use Dating for Sterile Compounded Drug Preparations.

In conformity with and ~~i~~in addition to the requirements and limitations of section 1735.2, subdivision (h), every sterile compounded drug preparation shall be given and labeled with a beyond use date that ~~conforms to the following limitations, except that the beyond use date shall~~ does not exceed ~~any~~ the expiration date or beyond use date provided by the manufacturer for any component in the preparation~~.~~, and that, in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference, that would justify a more extended beyond use date, conforms to the following limitations:~~,~~

(a) The beyond use date shall specify that storage and exposure periods cannot exceed 48 hours at controlled room temperature, 14 days at controlled cold temperature, and 45 days at controlled freezer temperature, ~~W~~where the sterile compounded drug preparation ~~was~~ is compounded solely with aseptic manipulations and all of the following apply:

(1) The preparation is compounded entirely within an ISO Class 5 PEC located in an ISO Class 7 buffer area or *cleanroom* with an ante-area, using only sterile ingredients, products, components, and devices; and

(2) ~~t~~The compounding process involves transferring, measuring, and mixing manipulations using not more than three commercially manufactured packages of sterile preparations and not more than two entries into any one sterile container or package of sterile preparations or administration containers/devices to prepare the drug preparation; and

(3) Compounding manipulations are limited to aseptically opening ampules, penetrating

disinfected stoppers on vials with sterile needles and syringes, and transferring sterile liquids in sterile syringes to sterile administration devices, package containers of other sterile preparations, and containers for storage dispensing. ~~in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia—National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference, that would justify a more extended beyond-use date, the beyond-use date shall specify that storage and exposure periods cannot exceed the following: 48 hours at controlled room temperature; 14 days at controlled cold temperature; and 45 days at controlled freezer temperature.~~

(b) The beyond use date shall specify that storage and exposure periods cannot exceed 30 hours at controlled room temperature, 9 days at controlled cold temperature, and 45 days at controlled freezer temperature, ~~W~~where the sterile compounded drug preparation ~~was~~ is compounded solely with aseptic manipulations and all of the following apply:

(1) The preparation is compounded entirely within an ISO Class 5 PEC located in an ISO Class 7 buffer area *or cleanroom* with an ante-area, using multiple individual or small doses of sterile preparations combined or pooled to prepare a compounded sterile preparation that will be administered either to multiple patients or to one patient on multiple occasions; and

(2) ~~t~~The compounding process involves complex aseptic manipulations other than the single-volume transfer; and

(3) ~~t~~The compounding process requires unusually long duration such as that required to complete dissolution or homogenous mixing. ~~in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia—National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference, that would justify a more extended beyond-use date, the beyond-use date shall specify that storage and exposure periods cannot exceed the following: 30 hours at controlled room temperature; 9 days at controlled cold temperature; and 45 days at controlled freezer temperature~~

(c) The beyond use date shall specify that storage and exposure periods cannot exceed 24 hours at controlled room temperature, 3 days at controlled cold temperature, and 45 days at

controlled freezer temperature, ~~W~~where the sterile compounded drug preparation ~~was~~ is compounded solely with aseptic manipulations ~~entirely within an ISO Class 5 PEC located in an ISO Class 7 buffer area with an ante-area,~~ using non-sterile ingredients, including manufactured preparations not intended for sterile routes of administration, or non-sterile devices, before terminal sterilization, or where the sterile compounded drug preparation lacks effective antimicrobial preservatives. ~~in the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference, that would justify a more extended beyond use-date, the beyond use-date shall specify that storage and exposure periods cannot exceed the following: 24 hours at controlled room temperature; 3 days at controlled cold temperature; and 45 days at controlled freezer temperature.~~

For the purposes of this ~~paragraph~~ subdivision, "non-sterile" includes sterile contents of commercially manufactured preparations, sterile surfaces of devices, and containers for the preparation, transfer, sterilization, and packaging of compounded sterile preparations, that are exposed to worse than ISO Class 5 air quality for more than one hour.

(d) The beyond use date shall specify that storage and exposure periods cannot exceed 12 hours ~~*in a laminar air flow workbench or biological safety cabinet*~~ ~~W~~where the sterile compounded drug preparation ~~was~~ is compounded solely with aseptic manipulations and all of the following apply:

(1) The preparation was compounded entirely within an ISO Class 5 PEC that is located in a segregated sterile compounding area and restricted to sterile compounding activities, using only sterile ingredients, components, and devices, by personnel properly cleansed and garbed; and

(2) ~~t~~The compounding process involves simple transfer of not more than three commercially manufactured packages of sterile nonhazardous preparations or diagnostic radiopharmaceutical preparations from the manufacturer's original containers; and

(3) ~~t~~The compounding process involves not more than two entries into any one container or package (e.g., bag, vial) of sterile infusion solution or administration container/device. ~~in~~

~~the absence of passing a sterility test in accordance with standards for sterility testing found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP37-NF32) Through 2nd Supplement (37th Revision, Effective December 1, 2014), hereby incorporated by reference, that would justify a more extended beyond use date, the beyond use date shall specify that storage and exposure periods cannot exceed 12 hours in a laminar air flow workbench or biological safety cabinet.~~

~~*(e) The beyond use date shall specify that storage and exposure periods cannot exceed 12 hours. W*~~*w*~~*here the sterile compounded drug preparation was compounded under both of the following conditions:*~~

~~*(1) U*~~*u*~~*sing or containing hazardous drugs or components; and*~~

~~*(2) I*~~*i*~~*n facilities that prepare a low volume of hazardous drugs, where low volume is defined as five or less per a week, and the use of two tiers of containment (e.g., closed system transfer device within a biological safety cabinet or compounding aseptic containment isolator that is located in a non-negative pressure room).*~~ ~~the beyond use date shall specify that storage and exposure periods cannot exceed 12 hours.~~

(~~*e*~~*f*)(1) Where any sterile compounded drug preparation was compounded either outside of an ISO class 5 PEC or under conditions that do not meet all of the requirements for any of subdivisions (a) through (e), the sterile compounded drug preparation shall be labeled "for immediate use only" and administration shall begin no later than one hour following the start of the compounding process. Unless the "immediate use" preparation is immediately and completely administered by the person who prepared it or immediate and complete administration is witnessed by the preparer, the preparation shall bear a label listing patient identification information, the names and amounts of all ingredients, the name or initials of the person who prepared the compounded sterile preparation, and the exact one-hour beyond use date and time. If administration has not begun within one hour following the start of the compounding process, the compounded sterile preparation shall be promptly, properly, entirely, and safely discarded. This provision does not preclude the use of a PEC to compound an "immediate use" preparation. A PEC used solely to compound 'immediate use' preparations need not be place~~s~~*d* within an ISO Class 7 buffer area or cleanroom, with an ante-area.

(2) Such "immediate use" preparations shall be compounded only in those limited situations where there is a need for immediate administration of a sterile preparation compounded outside of an ISO class 5 environment and where failure to administer could result in loss of life or intense suffering. Any such compounding shall be only in such quantity as is necessary to meet the immediate need and the circumstance causing the immediate need shall be documented in accordance with policies and procedures.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Add § 1751.9 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1751.9 Single-Dose and Multi-Dose Containers; Limitations on Use

(a) Single-dose ampules are for immediate use only, and once opened shall not be stored for any time period.

(b) Unless otherwise specified by the manufacturer, any single-dose container of a compounded sterile drug preparation other than an ampule, such as a bag, bottle, syringe or vial, shall be used in its entirety or its remaining contents discarded within the following time limit, depending on the environment:

(1) When needle-punctured in an environment with air quality worse than ISO Class 5, within one (1) hour;

(2) When needle-punctured in an environment with ISO Class 5 or better air quality, within six (6) hours.

(c) Unless otherwise specified by the manufacturer, a multi-dose container stored according to the manufacturer's specifications shall be used in its entirety or its remaining contents discarded within twenty eight (28) days from initial opening or puncture. Any multi-dose

container not stored according to the manufacturer's specifications shall be discarded immediately upon identification of such ~~*condition*~~*storage circumstance*.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Amend § 1751.10 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

~~1751.8.~~ 1751.10. Sterile ~~Injectable~~ Compounding Reference Materials.

In any pharmacy engaged in compounding sterile ~~injectable~~ drug ~~products~~ preparations, there shall be current and appropriate reference materials regarding the compounding of sterile ~~injectable~~ drug ~~products~~ preparations located in or immediately available to the pharmacy.

Authority cited: Sections 4005 and 4127, Business and Professions Code. Reference: Sections 4005, 4036, 4037, 4051, 4052, and 4127, Business and Professions Code.

To Add Article 7.5 of Division 17 of Title 16 of the California Code of Regulations to read as follow

Article 7.5 Furnishing for Home Administration

To Amend § 1751.10 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

~~1751.10.~~ 1752. Furnishing to Parenteral Patient at Home.

Subject to all provisions of this article, a pharmacist may carry and furnish to a patient at home dangerous drugs, other than controlled substances, and devices for parenteral therapy when the dangerous drug or device is one currently prescribed for the patient.

Authority cited: Section 4005, Business and Professions Code. Reference: Section 4005, Business and Professions Code.

To Amend § 1751.11 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

~~1751.11.~~ 1753. Furnishing to Home Health Agencies and Licensed Hospices.

Subject to the following conditions, a licensed pharmacy may furnish to a home health agency licensed under provisions of Chapter 8 (commencing with section 1725 of Division 2 of the Health and Safety Code) or to a hospice licensed under provisions of Chapter 8.5 (commencing with section 1745 of Division 2 of the Health and Safety Code) dangerous drugs for parenteral therapy other than controlled substances, in a portable container for furnishing to patients at home for emergency treatment or adjustment of parenteral drug therapy by the home health agency or licensed hospice.

(a) The pharmacy, having ownership and responsibility for the portable containers, shall ensure that each portable container is:

(1) furnished by a registered pharmacist;

(2) sealed in such a manner that a tamper-proof seal must be broken to gain access to the drugs;

(3) under the effective control of a registered nurse, pharmacist or delivery person at all times when not in the pharmacy;

(4) labeled on the outside of the container with a list of the contents;

(5) maintained at an appropriate temperature according to United States Pharmacopeia Standards (1995, 23rd Revision), and protected at all times from extreme temperatures that could damage the contents.

(b) The portable container may contain up to:

(1) 1000mL of 0.9% sodium chloride intravenous infusion in containers of a size determined by the pharmacy;

(2) 1000mL of 5% dextrose in water injection in containers of a size determined by the pharmacy;

(3) two vials of urokinase 5000 units;

(4) Each of the following items shall be in sealed, unused containers; the furnishing pharmacy may select any or all of these dangerous drugs in up to five dosage units for inclusion in the sealed, portable container:

(A) heparin sodium lock flush 100 units/mL;

(B) heparin sodium lock flush 10 units/mL;

(C) epinephrine HCl solution 1:1000;

(D) epinephrine HCl solution 1:10,000;

(E) diphenhydramine HCl 50mg/mL;

(F) methylprednisolone 125mg/2mL;

(G) normal saline, preserved, up to 30 mL vials;

(H) naloxone 1mg/mL 2 mL;

(I) droperidol 5mg/2mL;

(J) prochlorperazine 10mg/2mL;

(K) promethazine 25mg/mL;

(L) dextrose 25gms/50mL;

(M) glucagon 1mg/mL;

(N) insulin (human) 100 units/mL;

(O) bumetamide 0.5mg/2mL;

(P) furosemide 10mg/mL;

(Q) EMLA Cream 5 gm tube;

(R) Lidocaine 1 percent 30mL vials.

(5) The pharmacy shall ensure that the specific dangerous drugs and quantities to be included in the portable container are listed in the home health agency's or licensed hospice's policies and procedures.

(c) The pharmacy shall not supply a portable container to a home health agency or licensed hospice which does not:

(1) implement and maintain policies and procedures for:

(A) the storage, temperature stability and transportation of the portable container;

(B) the furnishing of dangerous drugs from the portable container upon the written or oral authorization of a prescriber; and

(C) a specific treatment protocol for the administration of each medication contained in the portable container.

(2) have the policies, procedures and protocols reviewed and revised (as needed) annually by a group of professional personnel including a physician and surgeon, a pharmacist and a registered nurse.

(d) A copy of these policies, procedures and protocols shall be maintained by the furnishing pharmacy from each home health agency or licensed hospice for which the pharmacy furnishes portable containers.

(e) In cases where a drug has been administered to a patient pursuant to the oral order of a licensed prescriber, the pharmacy shall ensure that the oral order is immediately written down by the registered nurse or pharmacist and communicated by copy or fax within 24 hours to the furnishing pharmacy, with a copy of the prescriber-signed document forwarded to the dispensing pharmacy within 20 days.

(f) The pharmacy shall ensure that within seven days (168 hours) after the seal has been broken on the portable container, the home health agency's director of nursing service or a registered nurse employed by the home health agency or licensed hospice returns the container to the furnishing pharmacy. The furnishing pharmacy shall then perform an inventory of the drugs used from the container, and if the container will be reused, must restock and reseal the container before it is again furnished to the home health agency or licensed hospice.

(g) The furnishing pharmacy shall have written policies and procedures for the contents, packaging, inventory monitoring, labeling and storage instructions of the portable container.

(h) The furnishing pharmacy shall ensure that the home health agency or licensed hospice returns the portable containers to the furnishing pharmacy at least every 60 days for

verification of product quality, quantity, integrity and expiration dates, or within seven days (168 hours) after the seal has been broken.
(i) The furnishing pharmacy shall maintain a current inventory and record of all items placed into and furnished from the portable container.

Note: Authority cited: Sections 4005 and ~~and~~ 4057, Business and Professions Code. Reference: Sections 4040, 4057, 4081 and 4332, Business and Professions Code.

To Amend § 1751.12 in Article 7 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

~~1751.12~~ 1754. Obligations of a Pharmacy Furnishing Portable Containers.

(a) A licensed pharmacy shall not issue portable containers to any home health agency or licensed hospice unless the home health agency or licensed hospice complies with provisions of section 1751.11.
(b) A licensed pharmacy shall cease to furnish portable containers to a home health agency or licensed hospice if the home health agency or licensed hospice does not comply with provisions of section 1751.11.

Note: Authority cited: Sections 4005 and 4057, Business and Professions Code. Reference: Sections 4040, 4057, 4081 and 4332, Business and Professions Code.