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ENFORCEMENT AND COMPOUNDING COMMITTEE REPORT
April 18, 2017

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Part 1: Enforcement Matters

a. Discussion and Consideration of the University of California, San Diego, Pilot Program to Permit Patients to Access Medications from an Automated Drug Delivery System (ADDS) Without Compliance with All Provisions of Title 16, California Code of Regulations section 1713

Attachment 1

Relevant Law
California Code of Regulations (CCR) section 1713(d) provides the requirements for use of an automated drug delivery system (ADDS).

Background
At the April 2015 board meeting, the board approved an 18-month pilot study under the auspices of the University of California, San Diego (UCSD), School of Pharmacy involving use of an automated drug delivery system (ADDS) for prescription medication from which staff of Sharp Hospital in San Diego and their families who opted in could pick up their outpatient medications. Consultation would be provided via telephone before medication could be dispensed to a patient for first-time fills.

Since that time the committee has received quarterly updates on the study, including patient use of the system. As authorized by the board, UCSD has collected data through the first quarter of 2017 and will report its findings at this board meeting. The board has permitted UCSD to continue operating the kiosk until the board makes a decision about the expanded use of the ADDS. The board could make this decision at this meeting.

Study Questions and Results
This project proposal was framed around five questions:

1. What is the patient prescription retrieval rate with 24/7 access through the ADDS as

compared with the historical and concurrent regular pharmacy counter rate?

2. Do employees of Sharp Memorial Hospital (SMH) believe the ability to pick up prescriptions at work would be beneficial and increase their adherence to medications?

3. Are patients who use the automated prescription delivery kiosk satisfied with their access to a pharmacist for questions and the convenience of the kiosk?

4. What is the mean time from prescription fill to patient pick-up at the automated prescription kiosk as compared with the same interval for prescriptions at the regular pharmacy counter?

5. Is the number or nature of questions for the pharmacist during consultation for new prescriptions different for prescriptions obtained in an on-worksite automated prescription delivery kiosk versus the regular pharmacy counter?

Committee Discussion

After receiving a presentation on the study, the committee discussed the information presented and noted that the quality of the patient/pharmacist encounter when a phone line was used versus a face-to-face encounter, noting that the types of questions asked with the in-person encounters were more clinical in nature. The committee also expressed concern with the small sample size but noted that the service provided by the ADDS may be better than mail-order pharmacy.

Ultimately, the committee determined it was uncomfortable recommending changes to section 1713, but requested that the study be brought forward to the full board for consideration

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Committee Recommendation: Bring the study for an open discussion by the board.

Recent Update: Staff was advised that the final written study results will not be available at this meeting, however a report documenting the preliminary results and responses to the study questions will be provided during the board meeting.

Attachment 1 includes a copy of the PowerPoint presentation provided by UCSD and the CCR section 1713.

b. Update on CURES 2.0 Prescription Drug Monitoring Program

Background

The CA Department of Justice, which operates CURES, converted to the exclusive support of only CURES 2.0 at the beginning of March. The new CURES 2.0 system contains features that were not available to pharmacists in the prior system. At the January Enforcement Committee meeting, the Department of Justice provided an overview of the new system and highlighted the new features that can be accessed by pharmacists. For example, enrollment in CURES is now a much simpler and fully online registration process.

Prior Discussion

At the January 2017 board meeting, the board identified multiple items for future change with respect to the CURES program and for staff to pursue statutory changes. These changes are:

1. Include the days' supply of medication dispensed in the patient activity report (PAR).
2. Permit prescribers to view the prescriptions where they are identified as the prescriber.
3. Reduce the period within which a dispenser must report data following dispensing to within 48 hours.
4. Add Schedule V prescriptions for reporting to the CURES system.

Committee Discussion

The committee was advised that the pharmacists can now see the days' supply of medication on the PAR reports. As part of the discussion, it was noted that there appears to be support from the medical profession to allow prescribers to view their own data. Legislation is needed to implement the reduction in the reporting period as well as the inclusion of Schedule V medications. Staff will continue to look for opportunities to identify the appropriate vehicle for these legislative proposals; it may be next year.

The committee did not take action on this item.

c. Summary of a Presentation by Stericycle of a New Device for Destruction of Controlled Substances in Health Care Facilities

The committee was provided with a brief presentation by Stericycle of a new process/device for use in health care facilities to destroy controlled substances. As part of the presentation, the committee was advised that the new device is tamper-proof and contains a carbon-based solution that renders the contents unpalatable.

d. Discussion and Consideration of the Use of Automated Drug Delivery Systems (ADDS) – Follow up from the February 2017 Board Meeting

Attachment 2

Relevant Law

Business and Professions Code (BPC) section 4186 establishes the provisions under which a community clinic can use an automated drug delivery system (ADDS).

Health and Safety Code (HSC) section 1261.6 establishes the provisions under which a pharmacy can use an ADDS in a skilled nursing facility.

Background

In February 2017, the board convened a special board meeting to focus on new technology that has been introduced to provide medications to patients. Many ADDS devices today offer features not addressed in pharmacy law. Accordingly the board invited vendors to present information about technological features and how the devices are affected by existing statutes. The board's goal was to seek ways to allow pharmacies to provide better quality care and service to patients while maintaining security and protecting the public from diversion of controlled substances and other prescription drugs. The board directed the Enforcement and Compounding Committee to continue to explore this topic and bring recommendations for action to a future board meeting.

In general, ADDS machines must "collect, control and maintain all transaction information to accurately track the movement of drugs into and out of the system for security, accuracy and accountability." Key regulatory provisions specify who is responsible for stocking an ADDS with medication and how restocking may be prepared outside the health facility where an ADDS is installed.

Committee Discussion

As part of its discussion, the committee discussed the options and features currently available as well as the refilling of ADDS in a skilled nursing facility.

The committee focused its discussion in two areas - medications that are administered (such as in a skilled nursing facility) and medications that are dispensed (such as in a community clinic).

The committee was advised that based on counsel's review of the provisions contained in HSC 1261.6, an ADDS may be stocked by a health care professional at a skilled nursing facility if all of the following conditions are met:

1. The ADDS utilizes removable pockets, cards, drawers, similar technology, or unit of use or single dose containers.
2. The stocking of those removable containers is performed by or under the direct supervision of a pharmacist.
3. The containers are transported between the pharmacy and the facility in a secure, tamper-evident container.
4. The pharmacy and facility have developed policies and procedures to ensure that the containers are appropriately placed in the ADDS.

The committee noted that the above conditions are the only exception to a pharmacist or pharmacy staff refilling an ADDS.

The committee was advised that a newsletter article will be written to clarify the conditions under which individuals other than pharmacy personnel may stock an ADDS. The committee received a number of scenario-specific questions regarding the restocking of the ADDS.

Committee Recommendation: Discuss with the board the outcome of the review by the committee as it relates to ADDS used for administration. Also, discuss the use of ADDS for dispensing medications.

During the board meeting, members may wish to consider the following questions as part of their discussion regarding the use of ADDS for dispensing medications:

1. Should the board expand the use of ADDS owned and operated by a pharmacy to locations currently not allowed under pharmacy law -- for example, a setting similar to that of the UCSD study? If so, what additional locations would be appropriate and what, if any, type of regulation and/or license should the board issue?

Depending on the answer to the above question, the following may be appropriate to consider as well.

2. Should someone other than an employee of the pharmacy access the system for purposes of replenishing the drugs? Could replenishing of the system be done via a remote camera with pharmacist review?
3. Should the board require some sort of biometrics or other technology to track access of the system?
4. Should there be limits on the types of drugs available through the machine for this purpose, e.g., 340B, no controlled substances, drugs that require reconstitution?
5. Should patient consultation be required before any drug is dispensed? Should consultation be completed via video versus phone?
6. Should health care professionals be required to provide the drug to the patient, or should the patient be able to access the medication independently via a vending machine model?
7. Should there be a limit on the number of ADDS per location?
8. Should there be a limit on the ratio of ADDS to remote pharmacists?
9. Would a pharmacist outside of California perform services such as online verification? If so, should such an individual be licensed as a pharmacist in California?

Attachment 2 includes a copy of the relevant laws as well as the technology grid reviewed by the committee.

e. Discussion and Consideration of a Proposed Regulation to Add Title 16 California Code of Regulations Section 1715.65 Related to Inventory Reconciliation of Controlled Substances

Attachment 3

Relevant Law

Throughout pharmacy law, there are requirements established to provide for the security of drugs. Some specific sections include:

- BPC section 4116 limits access to the pharmacy area and specifies that a pharmacist is responsible for any individual that enters premises. This section further requires the board to establish regulations requiring reasonable security measures.
- BPC section 4117 limits pharmacy access where controlled substances, dangerous drugs or dangerous devices are stored.

Further, Title 16, CCR section 1715.6, requires the owner of a pharmacy to report within 30 days of discovery of any loss of controlled substances, including their amounts and strengths.

Background

For over one year, the board has been discussing proposed new regulation requirements to ensure pharmacies more closely monitor and periodically count controlled substances as a means to reduce drug losses and to identify any losses sooner. The regulation in its current form requires a physical count and reconciliation of all Schedule II controlled substances every 90 days.

At the January 2017 board meeting, the board asked the committee to review the regulation text to determine if the board could improve its clarity. The board also asked the committee to consider whether the board should initiate a new rulemaking to amend section 1715.6 and determine if the board should replace the requirement to report "any" controlled substances drug loss to the board with "a significant" loss.

A chronology for development of the section 1715.65 regulation is:

Board approves initial version of regulation:	July 28, 2016
Proposed text released for 45-day public comment:	September 16-October 31, 2016
Board reviews comments and modifies text:	December 14, 2016
Modified text released for 15-day comment:	December 23, 2016-January 7, 2017
Board refers text to Enforcement Committee:	January 24, 2017

In its current form, the reconciliation regulation would:

- Require pharmacies, including inpatient pharmacies, and clinics (licensed by the board under sections 4180 and 4190) to count every quarter all Schedule II drugs in the licensee's possession. This will also include medications in ADDS machines owned by a pharmacy.
- Require that the reconciliation be signed by the PIC or, in the case of a clinic, the professional director. All records must be kept for three years and be readily retrievable.
- Reaffirm the reporting of losses as required by other sections of CA and federal law.
- Require that a new PIC perform an inventory reconciliation of all Schedule II controlled substances within 30 days of becoming PIC and encourage the outgoing PIC to perform a similar reconciliation before leaving his or her PIC position.

Committee Discussion

The committee discussed the proposed modifications to the section and identified additional changes to be included. The committee also discussed the current requirement for a pharmacy to notify the board of any loss of a controlled substance. The committee noted that DEA requirement for reporting a drug loss states "significant" loss. The committee was provided historical information about the policy behind the current reporting requirement.

After committee and public comment, the committee requested that additional changes be included in the proposed amendments. Such changes included:

- Moving the requirement of including identification of possible causes of overages from section (e) where it was a standalone requirement into the reporting requirements in section (c) relating specifically to the inventory reconciliation reporting activities for Schedule II controlled substances.
- Amending section (d) to replace the term "possible causes" with "known causes". Further, the section replaces the term "security improvements" with "action", noting that security improvements may not always be made, but action would always be expected.
- Amending several sections to clarify that the inventory reconciliation report requirement applies to Schedule II controlled substances as designated by federal law, noting that because of some differences between the state and federal schedules of some substances, clarity on the board's expectation was needed.

Nonsubstantive changes were also identified and made as well. An example of a nonsubstantive change in the regulation is replacing "Inventory Reconciliation Report" with "inventory reconciliation report"

After some discussion, the committee voted to move forward with the proposed changes (noted above) to the regulation and continue its discussion of the drug loss reporting requirement at a future meeting.

Committee Recommendation: Approve the proposed changed to Title 16, CCR section 1715.65, Inventory Reconciliation Report of Controlled Substances as approved by the committee and release for a 15-day comment period.

Attachment 3 includes the proposed modified text as approved by the committee as well as copies of the relevant laws.

f. Report on the March 11, 2017, Training Provided by the Board and DEA on CURES and Prescription Drug Abuse, and Possible Future Training

Attachment 4

The committee was advised that on March 11, 2017, the board, the Drug Enforcement Administration and UCSD provided a day-long conference on prescription drug abuse, corresponding responsibility and preventing drug losses from a pharmacy. There were nearly 200

attendees who earned six hours of continuing education credit for attending this training, and another 132 individuals who earned one additional hour of continuing education to secure the training needed to provide naloxone under California protocol. Evaluations of the training were positive.

The committee was also advised that an additional training session will be scheduled for other areas of California in the next fiscal year.

A copy of the agenda for the training is provided as **Attachment 4.**

g. Summary of the Report Submitted to the Assembly Budget Committee Regarding the Board's Prescription Drug Abuse Team

Attachment 5

Background

During the Legislature's 2016-17 state budget negotiations, the board was asked to provide a report on the initial results of the formation of a specific team of investigators to proactively identify and initiate investigations involving controlled drugs. This report was due in April 2017.

Committee Discussion

The committee noted the five questions covered in the report:

1. Narrative description of the preceding year's activities related to combatting prescription drug abuse.
2. Funding and expenses information, including the budgeted, allocated and expended money.
3. Number of positions and responsibilities.
4. Number of cases and disposition of cases referred to the Office of the Attorney General (AG) as a result of a case opened from a coroner report.
5. Number of hours spent combating prescription drug abuse, including separately identifying the total number of hours spent reviewing coroners' reports and submitting public records requests to obtain the reports.

As part of the discussion, the committee was advised that based on this review, key source data and analyses appear to be better indicators of when investigations may be warranted, including geospatial analysis and wholesaler data versus coroner's reports.

A copy of this report is provided in **Attachment 5.**

Part II: Compounding Matters

a. Report on Statistics Regarding Outcomes of Board of Pharmacy Compounding Inspections

Attachment 6

The committee heard a presentation on findings from sterile compounding inspections. The committee was advised of the outcome of 647 inspections have been conducted on sterile

compounding pharmacies, the majority of which were conducted as part of the renewal of a license versus issuance of a new license. Further, the committee was advised that of the 602 inspections conducted as part of a renewal, the board identified corrections at 311 of the locations and identified violations at 34 locations. Of the 45 inspections conducted for an initial license, the board identified corrections at 15 locations and violations at one location.

The committee was advised that the board has received 11 recall notices since July 1, 2016 and issued one cease and desist order.

Attachment 6 includes a copy of the presentation provided.

b. Discussion and Consideration of Waiver Requests for Compounding Construction Compliance Delays Pursuant to Title 16 California Code of Regulations, Sections 1735 et seq. and 1751 et seq. and the Process for Review and Appeals of Such Requests

Attachment 7

Relevant Law

Title 16 of the California Code of Regulations (CCR), section 1735.6 (f), states that where compliance with California's compounding regulations requires physical construction or alteration to a facility or physical environment, the board may grant a waiver for a period of time to permit the required physical changes.

CCR section 1751.4 establishes similar provisions relating to sterile compounding.

Background

Toward the end of 2016, the board established a waiver process to permit construction needed to secure a pharmacy's compliance with requirements for compounding with hazardous drugs. Application for any waiver must be made in writing, identify the provisions requiring physical construction or alteration, and provide a timeline for any such changes. The board is able to grant the waiver for a specified period when, in its discretion, good cause is demonstrated for the waiver.

At the October 2016 board meeting, the board delegated authority to the executive officer to process waiver requests with parameters from the board. The board further delegated authority for a committee assigned by the president (to include the president and Board Member Schaad) to hear waiver requests.

Update on Waiver Requests

As of March 30, 2017, the board received 601 waiver requests, 509 of which had been reviewed.

Source of Waiver

Site Type	Received	Percentage
Hospital with LSC	213	42%
Pharmacy with LSC	242	48%

Pharmacy (nonsterile only)	98	19%

- HSP: 213/480 = 44.3% HSPs applied for a waiver
- PHY: 242/6586= 3.67% PHYs applied for a waiver
- NRP: 15/ 513= 2.92% of NRPs applied for a waiver

Outcomes

Site Type	Number	Percentage
Approved	289	57%
Denied	47	9%
Withdrawn	45	9%
In Process	128	25%

Committee Discussion

As part of its discussion, the committee was advised that initially staff met with Dr. Gutierrez, Mr. Schaad and usually representatives of the Office of Statewide Health Planning and the California Department of Public Health to normalize the reviewing and processing of the waiver requests. This process has now been refined to have the initial review performed by staff led by the executive officer, who approves or denies the waiver request. If a waiver is denied by the executive officer, there is an appeal process that will be reviewed by two board members, currently Board Members Schaad and Law.

The committee expressed concern about hardships to facilities seeking waivers and whether facilities understand their appeal rights in the event a waiver is denied.

Recent Update

Since the committee meeting, board staff and counsel have worked to refine the waiver outcome communications as well as the appeal process. Staff notes that as part of the appeal process, appeals will be heard in public and deliberated by the two board members assigned to hear such matters.

Attachment 7 includes a copy of the relevant laws the general waiver request forms.

c. Update on the Board's Progress in Implementing California Business and Professions Code Section 4129 et seq., regarding Licensure of Outsourcing Facilities

Background

Effective January 1, 2017, the board received the authority to license in-state and nonresident outsourcing facilities. This is an entirely new function and type of licensee from what the board has licensed in the past. The board believes it will receive three new staff members (two inspectors, one supervising inspector) for this program beginning July 1.

Committee Discussion

The committee discussed how outsourcing facilities will be regulated, including compliance with cGMPs. The committee was advised that the board has received 28 applications for outsourcers.

(Five of these are in California.) There are currently 68 outsourcing facilities listed on the FDA's website; however, not all registered facilities may seek licensure in California.

d. Discussion and Consideration of the United States Government Accountability Office's March 31, 2017, E-Supplement Report to Congressional Committees on Drug Compounding: FDA Has Taken Steps to Implement Compounding Law, but Some States and Stakeholders Reported Challenges

Attachment 8

Background

At the last Enforcement and Compounding Committee meeting, the committee reviewed a GAO report on the FDA's implementation of compounding law, titled: *Drug Compounding: FDA Has Taken Steps to Implement Compounding Law, but Some States and Stakeholders Reported Challenges* (GAO-17-64).

At the end of March 2017, the GAO released an e-supplement, which is a companion piece to the drug compounding report that was issued in November 2016. The e-supplement is an internet-only product that provides selected results from the GAO survey of state regulatory bodies on drug compounding, including additional data that are not included in the report.

The e-supplement is titled: *Drug Compounding: Survey of State Pharmacy Regulatory Bodies (GAO-17-363SP, March 2017), an E-supplement to GAO-17-64*. The information can be accessed at: http://www.gao.gov/products/GAO-17-363SP

Attachment 8 contains one example of some of the data displayed in these e-supplement tables.

e. Presentation by Road Runner Pharmacy Regarding Compounding for Veterinary Prescriber Office Use

Attachment 9

Relevant Law

CCR section 1735 et. seq, and CCR section 1751 et. seq, establish the requirements for compounding drug preparations.

Specifically CCR section 1735.2, among other things, specifies the requirements for establishing a beyond use date (BUD) for a compounded preparation.

Background

Road Runner Pharmacy requested the opportunity to address the board on compounding for veterinary prescriber office use at a future meeting. Specifically, Road Runner Pharmacy requested time to make a presentation seeking an exemption from the board's compounding regulations for veterinary compounding. This matter was referred to the Enforcement and Compounding Committee.

The board also received several letters from entities indicating that the board's regulations are negatively impacting patients and their pets.

Committee Discussion

Road Runner Pharmacy provided a presentation at this meeting regarding its concerns about the board's regulations related to the requirements for the establishment of beyond use dating (BUD) of products, including the need for method suitability tests, container closure integrity tests and stability studies. As part of the presentation, representatives highlighted some of the challenges for compounding medications for animals. Road Runner questioned if the regulations in this area are appropriate for compounding products for animals. Presenters noted the costs to perform the tests needed to comply with the regulations and noted that such tests would raise the costs for pet owners. As an example, Road Runner noted that method suitability tests and container closure integrity tests normally associated with sterile products are now mandated for nonsterile products if BUD extension can occur. Additionally, stability studies in the same paragraph can be interpreted differently. Using stability indicators – a common process used in manufacturing – could add as much as $20,000 to the BUD analysis. The result is a dramatic increase in costs to pet owners – most of whom have no insurance – and a dramatic decrease in pet care.

As part of the discussion the committee was advised that the current regulations are consistent with USP <795> requirements and that a pharmacy could rely on a published study under the provisions of CCR Section 1735.2(i)(4).

The committee heard comments both in support of the request as well as opposed to the request. The committee decided that a special meeting to focus on several different aspects of the board's compounding regulations was needed, in addition to a discussion on veterinary care.

Recent Update

An Enforcement and Compounding committee meeting has been scheduled for June 2, 2017, in Orange County. The meeting will focus on the board's current regulations and what, if any, changes need to be made to the regulations.

Attachment 9 includes a copy of the Road Runner Pharmacy summarized statement excerpt from the January 24, 2017, board meeting minutes as well as the relevant law.

f. Discussion and Consideration of the Proposed Food and Drug Administration Rule, "List of Bulk Drug Substances That Can Be Used to Compound Drug Products in Accordance with Section 503A of the Federal Food, Drug, and Cosmetic Act" and Proposed Lists

Attachment 10

Background

Under section 503A of the Food, Drug and Cosmetic Act, a bulk drug substance that is not the subject of a USP or NF monograph or is not a component of an FDA-approved drug

cannot be used in compounding unless it appears on a list promulgated by the FDA. However, until the substance has been evaluated and either included or not included on the bulks list, the FDA does not intend to take action if the product fits specific criteria (page 9).

Committee Discussion

The committee noted that the specific guidance document establishes an interim list of bulk substances that may be used by compounding pharmacies. The proposed rule also proposes other bulk drug substances the FDA has reviewed and classified as not to be added to the bulks list. Since December 2013, over 2,000 substances have been nominated to the FDA for listing on the bulks list; many of these can be used without inclusion on the bulks because they are subject of an applicable USP or NF monograph or are a component of an FDA-approved drug.

One of the conditions that must be met for a compounded drug product to qualify for these exemptions is that a licensed pharmacist, or licensed physician compounds the drug product using bulk drug substances that:

1. Comply with the standards of an applicable United States Pharmacopeia (USP) or National Formulary (NF) monograph, if a monograph exists, and the USP chapter on pharmacy compounding;
2. If such a monograph does not exist, are drug substances that are components of drugs approved by the Secretary; or
3. If such a monograph does not exist and the drug substance is not a component of a drug approved by the Secretary, appears on a list developed by the Secretary through regulations issued by the Secretary under subsection (c) of section 503A.

The bulk drug substance must be manufactured in an FDA-approved plant and accompanied by a certificate of analysis.

The committee did not take action on this item but will make the information available on the board's website.

Attachment 10 includes a copy of the guidance document

g. Discussion and Consideration of the Food and Drug Administration Rule "Interim Policy on Compounding Using Bulk Drug Substances Under Section 503B of the Federal Food, Drug, and Cosmetic Act – Guidance for Industry" and Proposed Lists

Attachment 11

Background

A bulk drug substance cannot be used in compounding unless it is used to compound a drug that appears on the FDA drug shortage list at the time of compounding, distributing and dispensing; or it appeared on the drug shortage list within 60 days of compounding. According to this guidance document, the FDA is considering the following factors in

developing a bulks list for outsourcers:

- Safety concerns about use of the bulk drug substance in compounding.
- Whether the bulk drug substances was nominated by multiple parties or identified as necessary by medical professional organizations.
- The efficiency with which the evaluation can be completed (ease of acquiring the information to conduct the review, available resources and other logistical issues).

Committee Discussion

The FDA intends to publish a guidance document in the *Federal Register* that describes its proposed position on each substance it has evaluated and why it will or will not add each to the outsourcing bulks list. It will seek the federal Pharmacy Compounding Advisory Committee's review when it believes their input may be helpful.

Attachment 11 includes a copy of the guidance. Staff notes that the last pages of the guidance provide three lists: a list of substances that are under evaluation for the bulk drug substances list for outsourcers, bulk substances that raise significant safety risks, and a list of substances that were nominated "without adequate support." This item will be added to the board's website.

h. Discussion and Consideration of the Food and Drug Administration Rule "Guidance for Industry Compounding Animal Drugs from Bulk Drug Substances" and Proposed Lists

Attachment 12

Background

Regulations developed by the FDA for animal drugs specify that bulk drug substances cannot be used to compound animal drugs. However, the FDA also notes that because either no drug is approved for a specific animal species or a drug is available under extra label use provisions, an animal drug compounded from bulk drug substances may be an appropriate treatment option. Nevertheless the FDA states that the "unrestricted compounding of animal drugs from bulk drug substances has the potential to compromise food safety, place animals or humans at undue risk from unsafe or ineffective treatment, and undermine the incentives to develop and submit new animal drug applications to FDA containing data and information to demonstrate that the product is safe, effective, properly manufactured, and accurately labeled."

Committee Discussion

The guidance provides that the FDA does not intend to take action if a state-licensed pharmacy, licensed veterinarian or outsourcer compounds animal drugs from bulk drug substances if operating under specified conditions. These include:

- If in a pharmacy, the animal drugs are compounded under the direct supervision of a pharmacist, after receipt of a prescription from a vet or based upon prescribed prior experience.
- If the compounded product is not used for food producing animals.
- If the bulk substance is part of an approved animal or human drug, there is a change

from the approved drug that produces a clinical difference for the animal.
- And numerous other factors detailed in the guidance.

As part of its discussion, the committee discussed this guidance as part of the context of the Road Runner request. The committee heard concerns about the conflict between the board's compounding regulations that allow for compounding for prescriber office use versus the guidance issued by the FDA that is outside operating as a 503A (pharmacy versus compounding pharmacy).

Part 3: General Committee Matters

Enforcement Statistics

Attachment 13

Attachment 13 contains statistics describing the enforcement activities of the board. During the first three quarters of the fiscal year, the board has initiated 2,231 investigations, closed 2,369 and had 2,241 pending.

The board denied 55 applications, issued 370 letters of admonishment, issued 1,505 citations/citations and fines, and referred 252 investigations to the Office of the Attorney General.

The board also secured one interim suspension order, one automatic suspension (based on a conviction), and eight Penal Code section 23 restrictions; and issued one cease and desist order for sterile compounding violations.

Minutes from the Enforcement and Compounding Committee Meeting will be provided during the meeting.

Attachment 1

Study of Expanded Use of an Automated Delivery Device

STUDY RESULTS
April 18, 2017

Jan D. Hirsch, BPharm, PhD
UCSD Skaggs School of Pharmacy & Pharmaceutical Sciences

UC San Diego
HEALTH SCIENCES

Outline

- Study Results
  - Pre-Kiosk Employee Survey
  - Satisfaction with Kiosk
  - Comparison Kiosk to Regular Counter
    - Return to Stock (RTS)
    - Time to Pick-Up
    - Consultations
- Next Steps

Kiosk = ScriptCenter

UC San Diego
Skaggs School of Pharmacy and Pharmaceutical Sciences

ScriptCenter Kiosk
Sharp Memorial Hospital

First Floor Lobby Sharp Memorial Hospital

UC San Diego
SKAGGS SCHOOL OF PHARMACY AND PHARMACEUTICAL SCIENCES

Quasi-experimental with non-randomized control group

Study Design

- *Pre-Kiosk Implementation Survey (Sharp Employees)* October-November 2015

Study Start

Month 1: *March* | Month 6: *August* | Month 10: *December*

6 months pre-kiosk
(September 2015 – February 2016)

Regular Counter

- RTS rate*

Kiosk

- RTS rate
- Consultation Log
- Time to Pickup
- Kiosk Patient Satisfaction

Regular Counter

- RTS rate*
- Consultation Log *(Sample: New Rxs weeks of 5/23&6/6 &12/5)*
- Time to Pickup*

Kiosk Go Live Date: 1/20/16
Study Start: 3/1/16

RTS = Return to Stock

* For employees and dependents

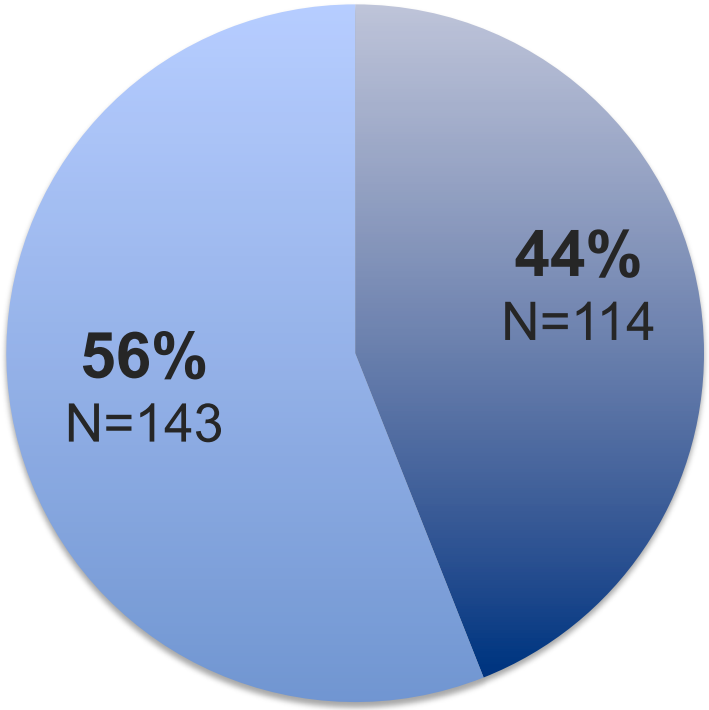
UC San Diego
Skaggs School of Pharmacy and Pharmaceutical Sciences

Pre-Kiosk Employee Survey Results

October – November 2015

UC San Diego
SKAGGS SCHOOL OF PHARMACY AND PHARMACEUTICAL SCIENCES

Do you pick up your or your family's prescriptions from a Sharp Rees-Stealy pharmacy?

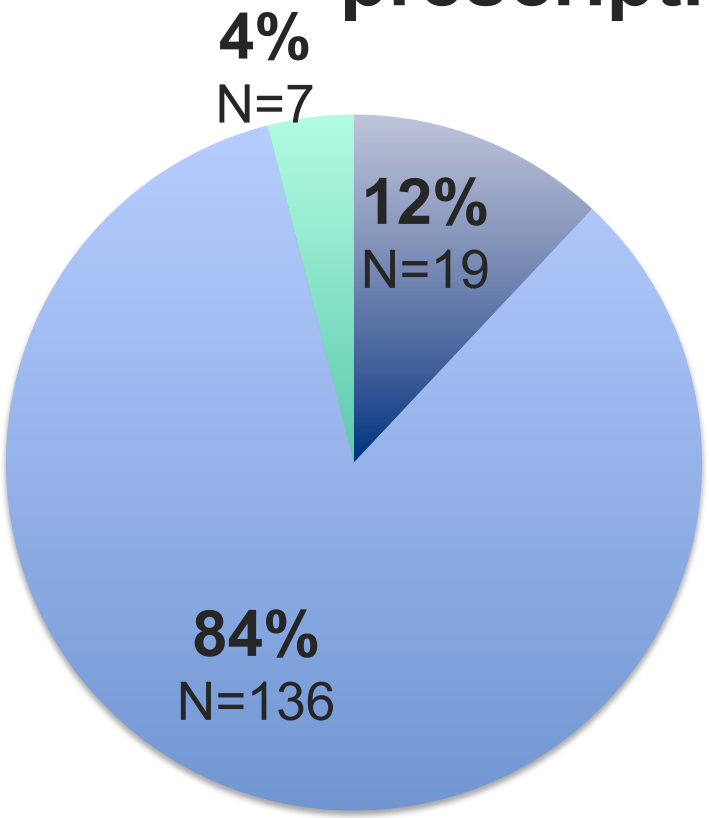


Total responses: 257

4.3% of 6,000 employees receiving

UC San Diego
Skaggs School of Pharmacy and Pharmaceutical Sciences

If no, how do you get your prescriptions?



Total responses: 162

UC San Diego
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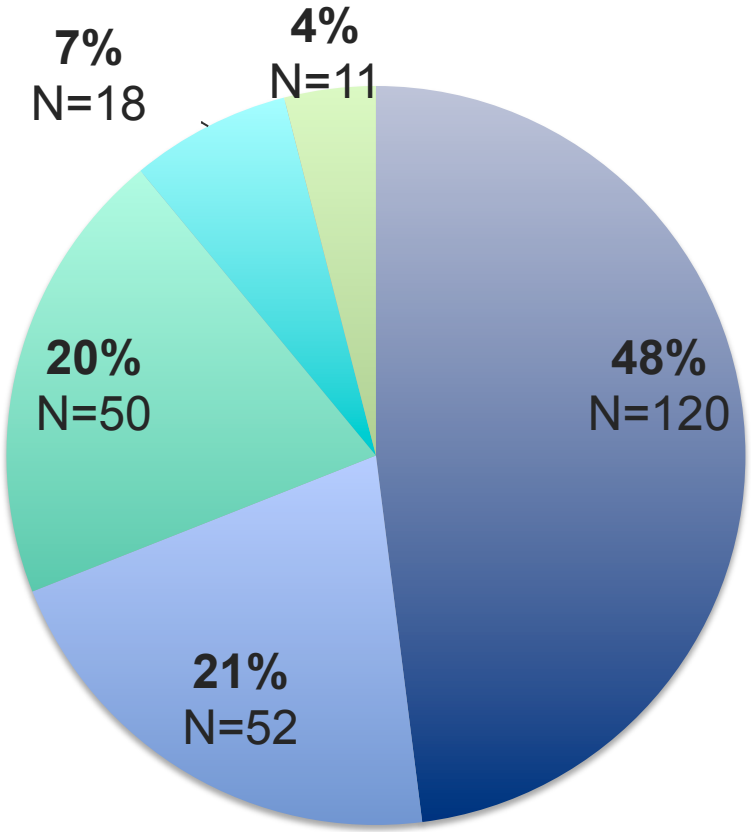
If I had easier access to my prescriptions, I would be more likely to pick up my medications.



Total responses: 251

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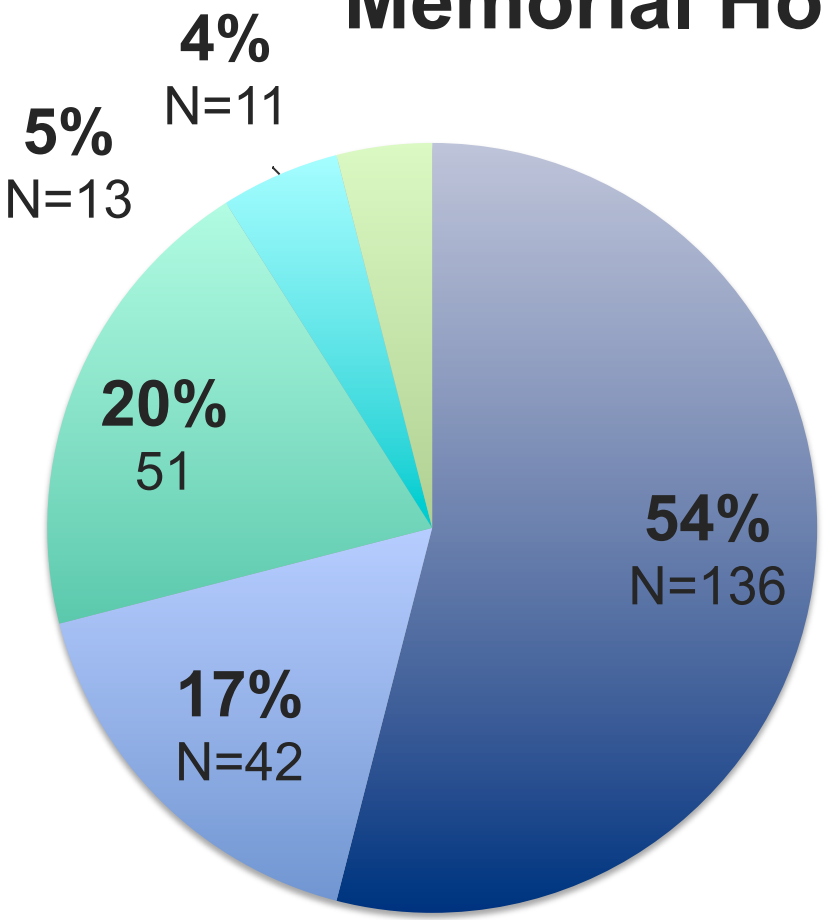
I would benefit from being able to pick up prescriptions at Sharp Memorial Hospital



- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

Total responses: 253

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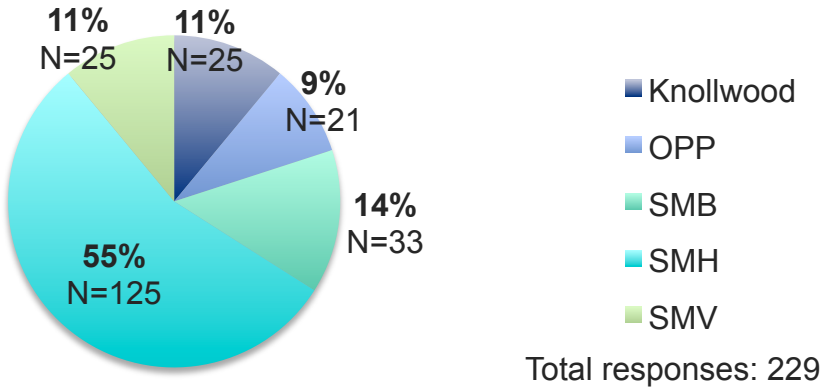
Where is your usual work location?



- *Greater percentage SMH employees (80%) agreed would be a benefit to pick up at SMH (kiosk location) than employees at other work locations (48% - 66%)*
- *About 40% currently pick up Rxs at SRS Rx – regardless of work location*

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Kiosk Operations Data

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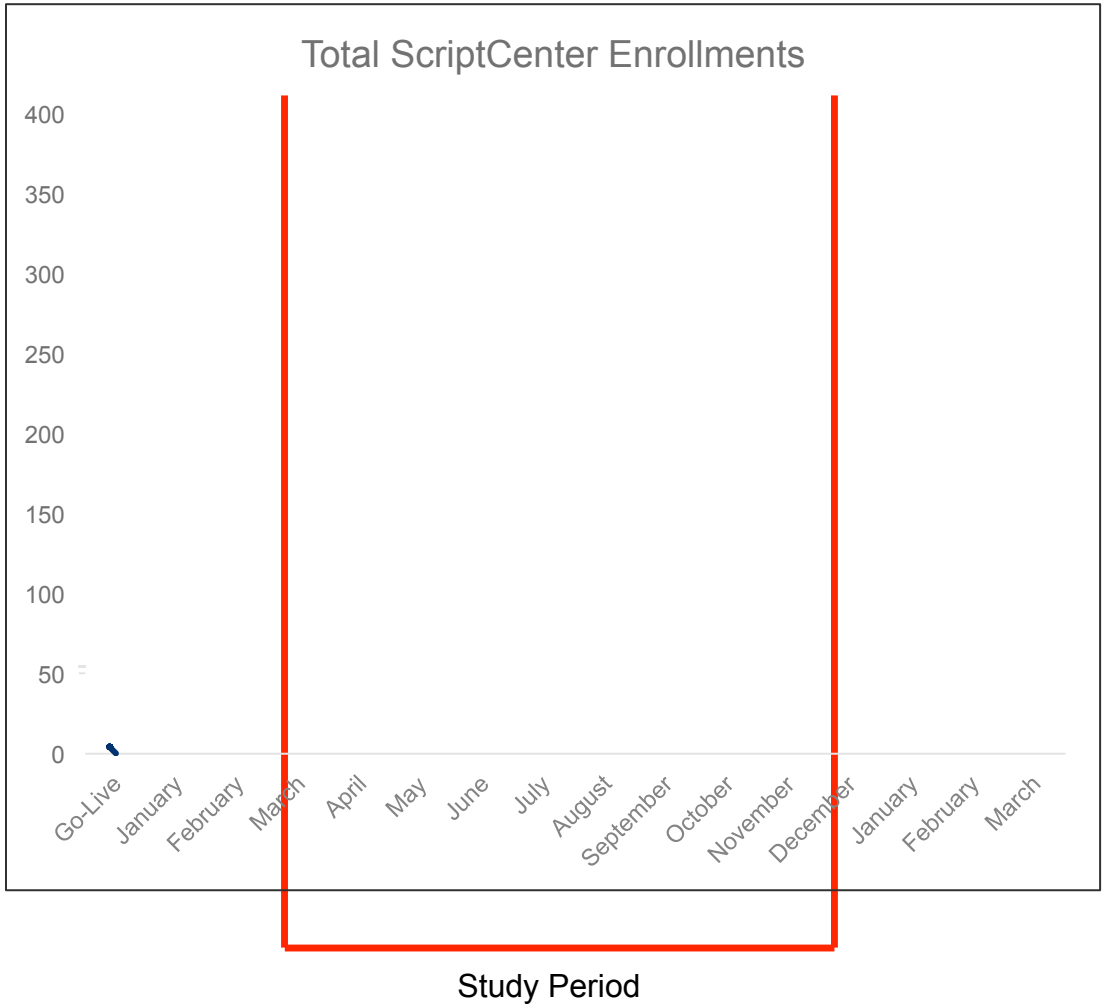
Kiosk Go Live Date: 1/20/16
Study Start: 3/1/16

ScriptCenter Kiosk Activity 1/20/16 through 3/22/17

ENROLLMENT



368 users
(8% Campus Employees)

Total Campus Employees
4,820
- Day Shift = 2,592
- PM+ Variable = 2,228

If estimate 2 per household
= 9,640

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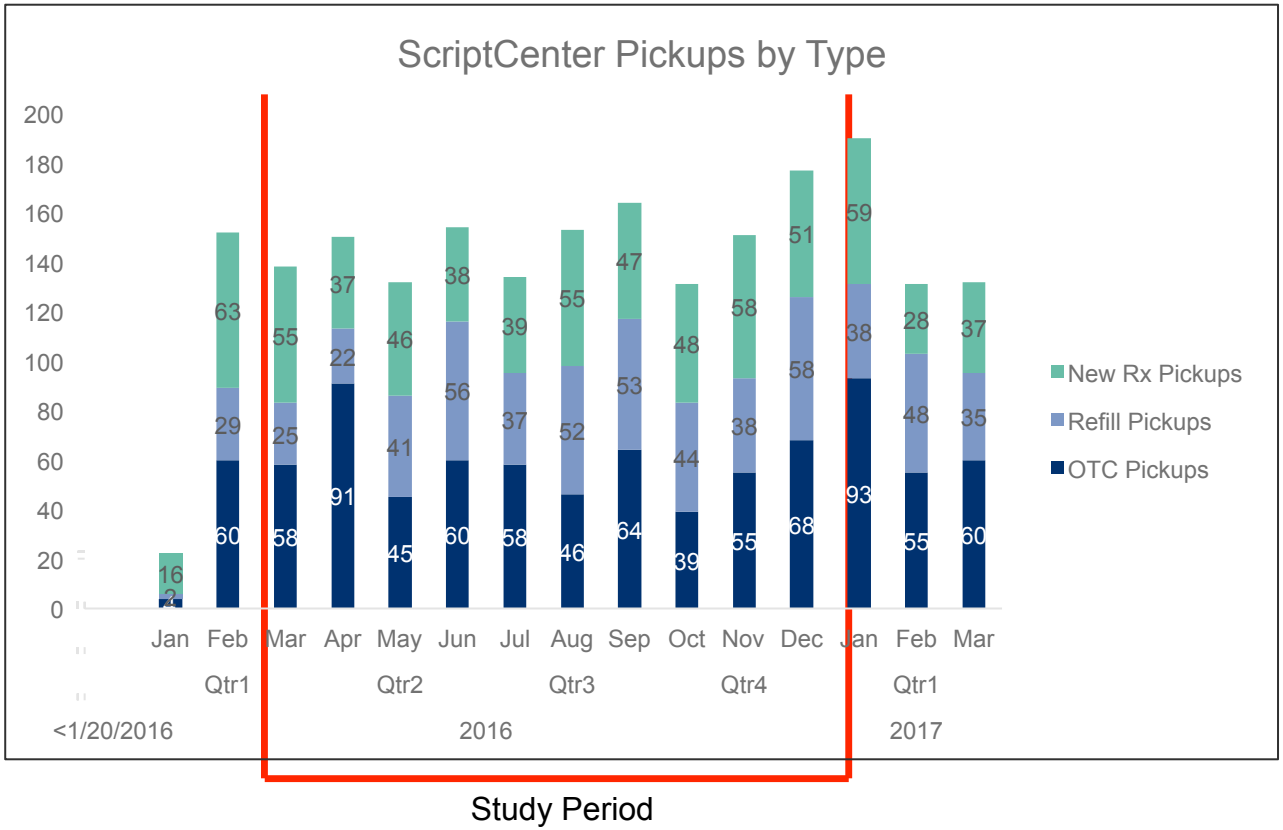
ScriptCenter Kiosk Activity 1/20/16 through 3/22/16

Pickups by Type

Kiosk Go Live Date: 1/20/16
Study Start: 3/1/16 Study End: 12/31/16



Study Period

- Fairly evenly divided among
  - New Rxs,
  - Refill Rxs
  - OTCs

368 Users

New prescription # (number) is ScriptCenter tracking method, some may not be "new" to pharmacy or patient

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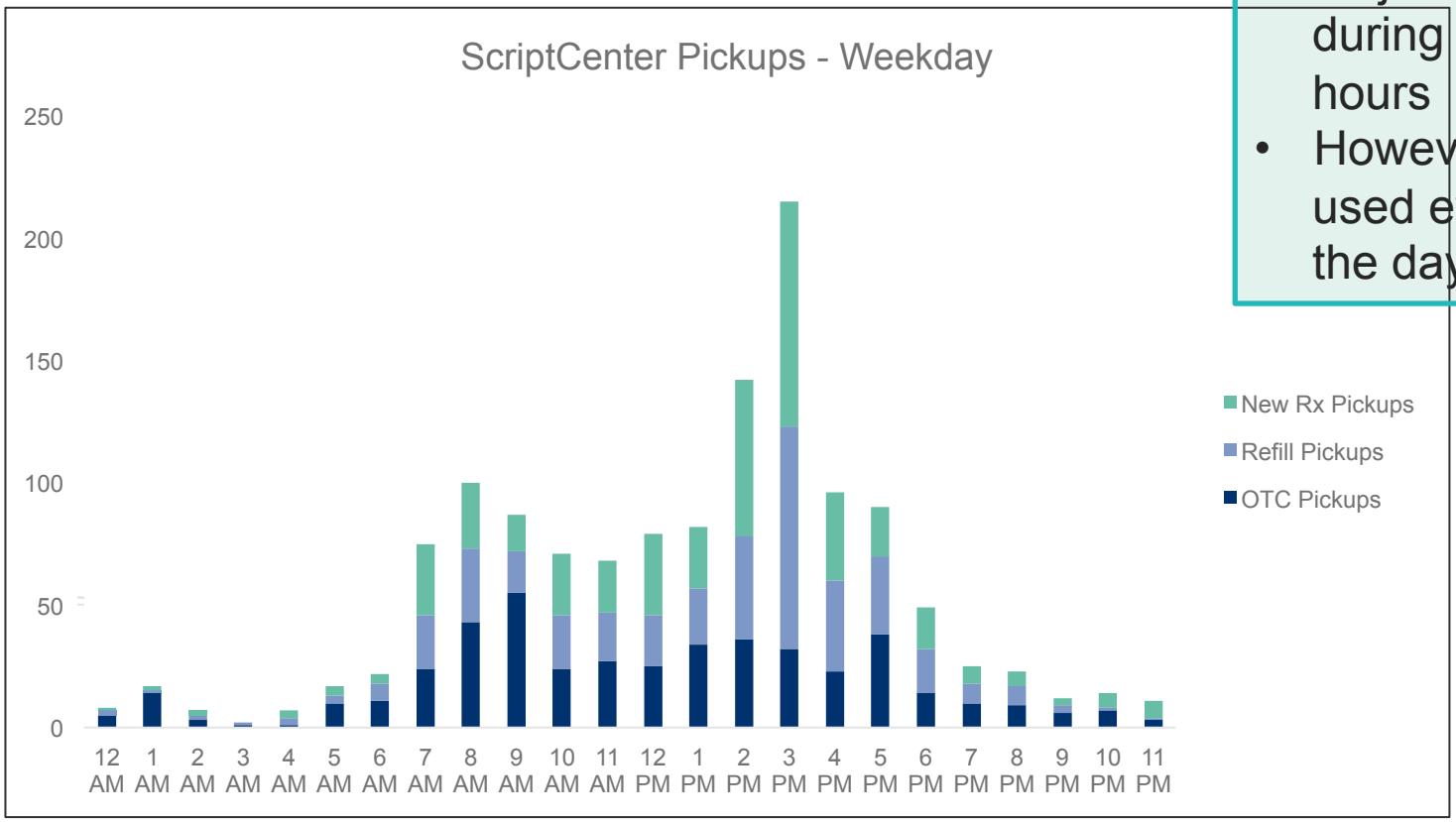
Pickups by Time Weekday

ScriptCenter Kiosk Activity 3/1/16 through 12/31/16 *(study period)*

- Majority picked up during pharmacy hours
- However, kiosk used every hour of the day



368 Users

Day Shift = 2,592 PM+ Variable = 2,228

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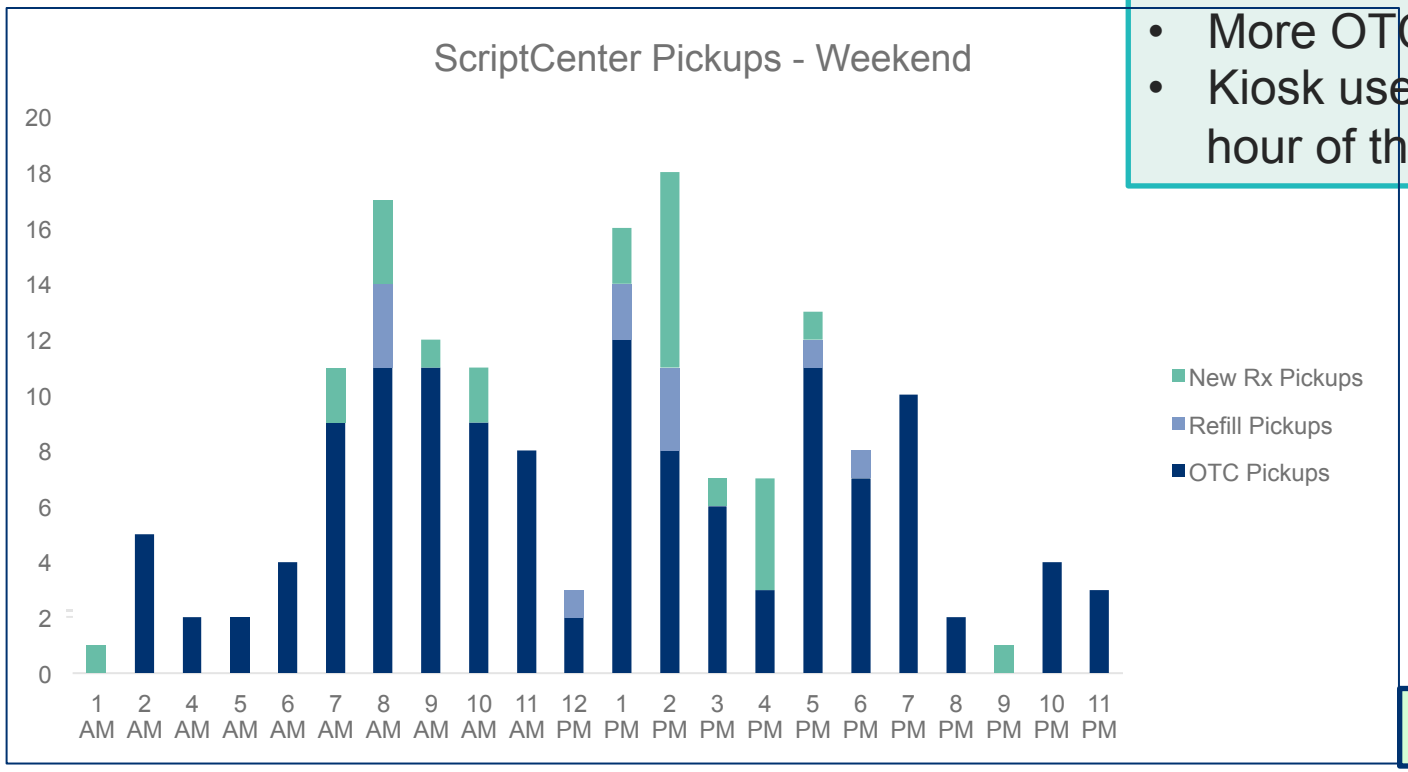
Pickups by Time Weekend

ScriptCenter Kiosk Activity 3/1/16 through 12/31/16 *(study period)*

- Lower volume on weekend
- More OTCs
- Kiosk used every hour of the day



368 Users

Pharmacy Closed

Day Shift = 2,592 PM+ Variable = 2,228

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ScriptCenter Kiosk
During vs. After Hours Pickup *(study period)**

1,484 Total Pickups

1,067 (72%) During pharmacy hours
417 (28%) After pharmacy hours

474 New Rx Pickups

366 (77%) During pharmacy hours
108 (23%) After pharmacy hours

426 Refill Rx Pickups

349 (82%) During pharmacy hours
77 (18%) After pharmacy hours

584 OTC Pickups

352 (60%) During pharmacy hours
232 (40%) After pharmacy hours

- Majority of Rxs (new and refill) picked up during pharmacy hours
- OTC pickups more evenly split

Day Shift: 2,592
PM + Variable: 2,228

368 Users

* Previous updates to Enforcement Committee had included pre-study period.
After hours includes weekday & weekend times pharmacy is closed.

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Post-Kiosk Use Satisfaction Survey

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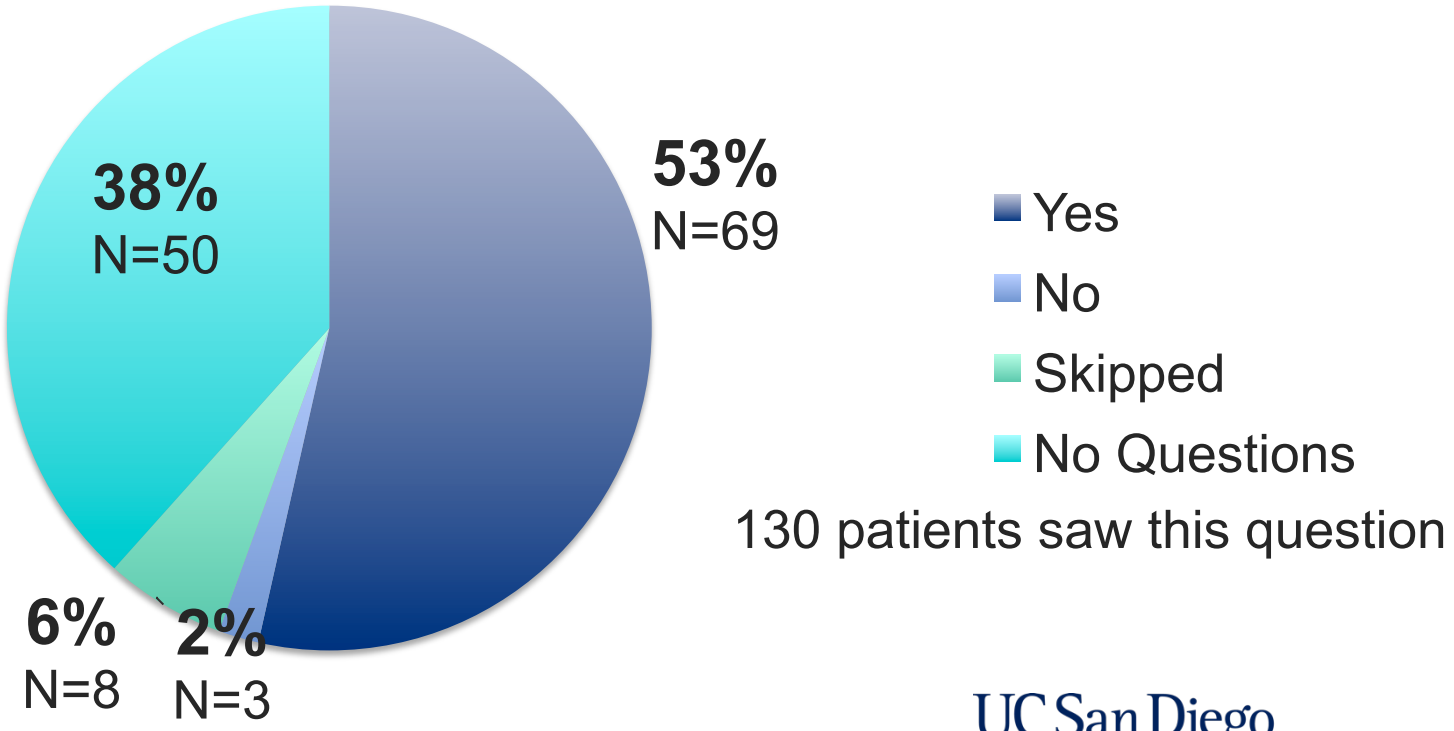
Do you feel your questions were answered regarding the prescriptions you picked up today?



Percentages do not add to 100% due to rounding error

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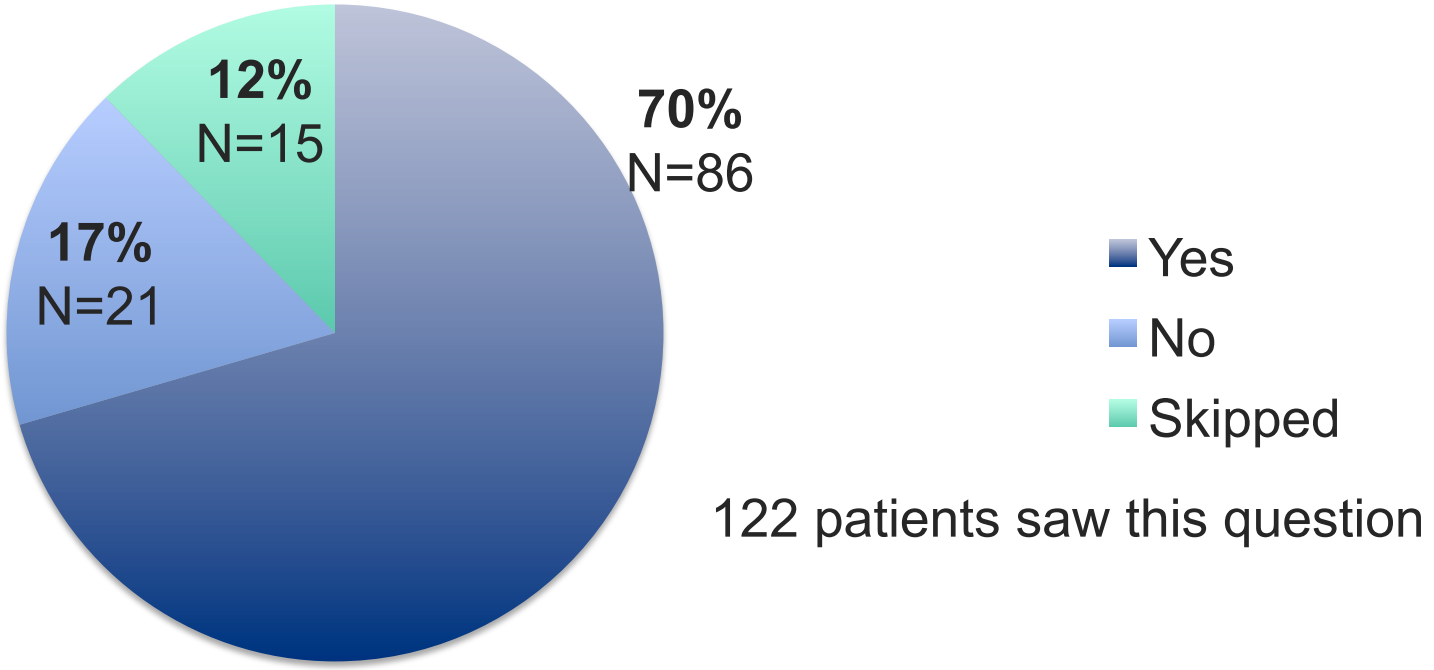
If you have questions for a pharmacist regarding the prescriptions you picked up today, do you know where to call?



Percentages do not add to 100% due to rounding error

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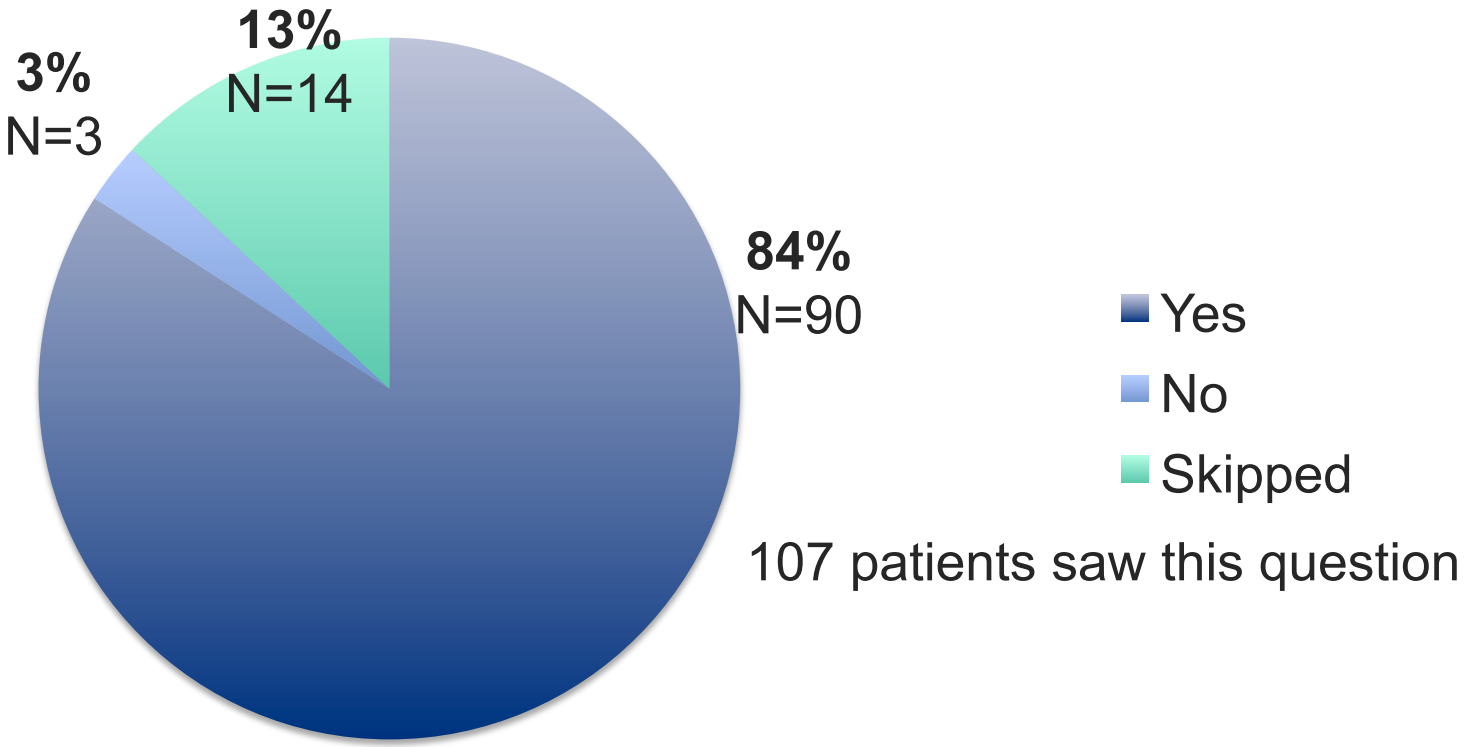
Is the convenience of after-hours prescription pick-up an important reason to use this pharmacy?



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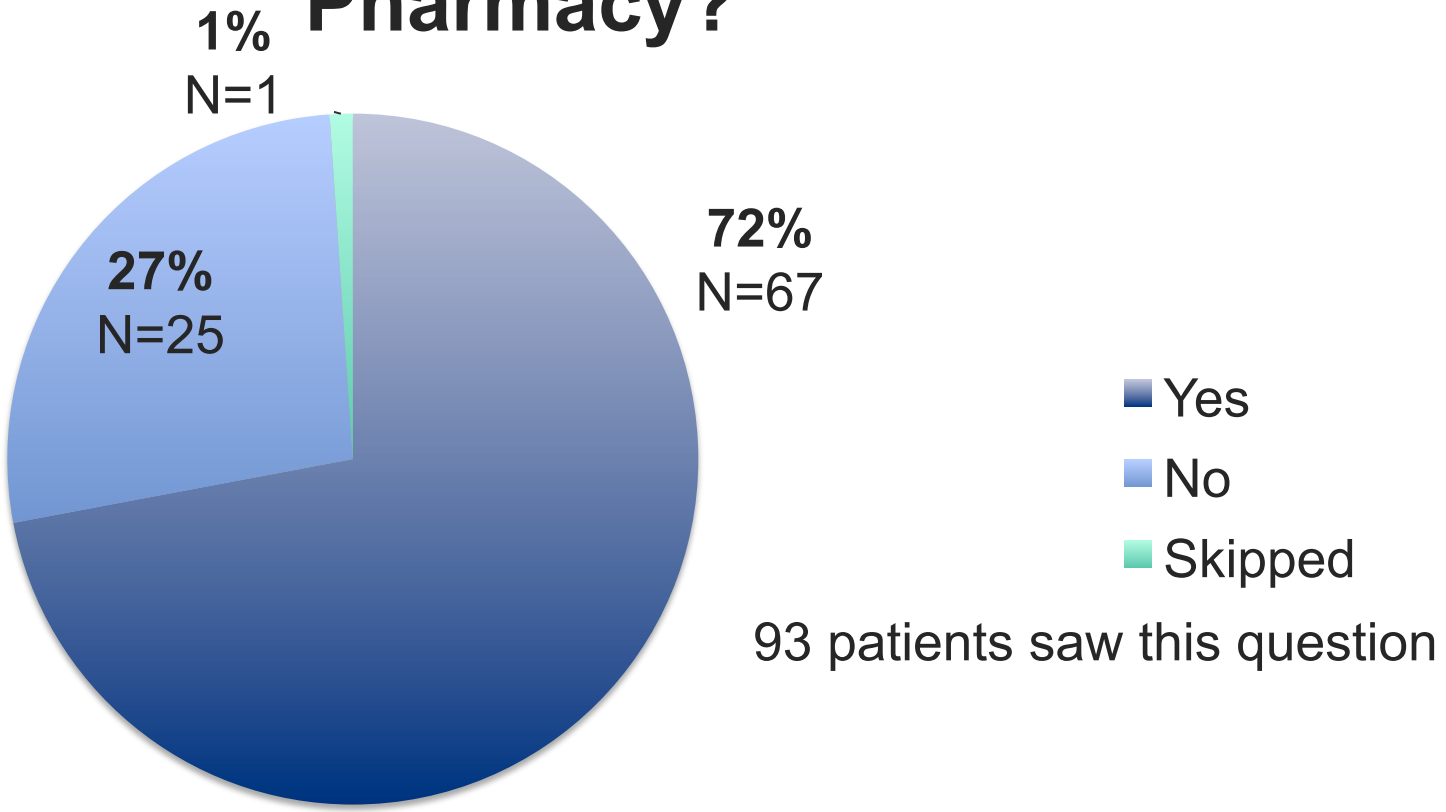
Is ScriptCenter a main reason for you to use the Sharp Rees Stealy Pharmacy?



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Regular Counter vs. Kiosk

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RTS Rate: Regular Counter vs. Kiosk

	Total Rx Filled	Total Rx Picked Up	Total Rx RTS	Mean* Monthly RTS (%)
Regular Counter (6 months prior)	4,924	4,668	256	5.2 ± 1.2
Regular Counter (study period)	7,015	6,643	372	5.3 ± 1.3
Kiosk**	943	893	50	5.0 ± 3.9

No significant difference in mean RTS at Kiosk vs. Regular Counter
(p = 0.942 6 months prior, p = 0.834 study period)

Regular Counter = Employees and Dependents only to "match" group using Kiosk

* Monthly mean over 10 month study period or 6 month pre-study
** 1 Kiosk patient had 3 RTS for 2 and 4 RTS for 1 of 10 months,
1 Kiosk patient had 1 RTS for 4 and 4 RTS for 2 of 10 months

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Time Verify to Pick up: Regular Counter vs Kiosk

	Days (Mean ± SD)	**Hours** (Mean ± SD)	**Range**
Regular Counter	1.8 ± 0.2	42.2 ± 3.9	15 sec to 28.9 days
Kiosk	3.0 ± 0.6	71.5 ± 14.5	7 min to 17.6 days

Mean time to pick up was greater at Kiosk vs. Regular Counter ($p < 0.001$)

Regular Counter = Employees and Dependents only to "match" group using Kiosk

Differences by Therapeutic Categories

Antibiotics
Antifungals
Antivirals
Antiparasitics
Contraceptives*
Antidiabetics
Cardiovascular Agents
Antihyperlipidemics*
Cough & Cold Products
Respiratory Products
Antidepressants*
Anticoagulants
*Dermatologic Agents**
Diagnostic Aids*
*Other Class**

Time to Pick Up: Kiosk mean greater (range 1.4 to 4.9 days)
** RTS %: Kiosk rate greater (range 0.3 to 10.1 percentage points)*

Data in appendix slides.

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Patient Consultations: Counter vs. Kiosk

	Counter (sample)	Kiosk
Number of consultation logs	151	169
n(%) consultations patient had:		
• no more questions	100 (66.2%)	137 (81.1%)
• more questions	51 (33.8%)	32 (18.9%)
Average number questions if patient had more questions	1.1 (56 Q's/51 logs)	1.1 (35 Q's/32 logs)

Percentage consultations with *no more questions* greater at Kiosk vs. Regular Counter (p =0.002)

A sampling of counseling sessions at the Regular Counter was conducted. Logs completed during 3 one week periods (May, June, December 2016)

Types of Patient Questions

- Kiosk Operations
- General Pharmacy Operations
- Drug Related (including cost)

Question Type	Regular counter	Kiosk
Kiosk Operations	0 (0%)	5 (15%)
General Pharmacy	0 (0%)	4 (12%)
Drug Related	44 (100%)	24 (73%)

Based on examination of “Types of Questions” appendix slides. Number of questions lower than on “Patient Consultations: Counter vs. Kiosk” slide since appendices did not report duplicates and pharmacist did not always specify type of question.

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Consultations: Initiation, Conduct & Duration

Consult initiated by*	Regular counter	Kiosk
Pharmacist	151 (100%)	144 (85.7%)
Patient	0 (0%)	24 (14.3%)

Kiosk patients received text message: asked to call back for counseling

Consult conducted	Regular counter	Kiosk
Counter	151 (100%)	1 (0.6%)
Phone	0 (0%)	168 (99.4%)

All but one Kiosk consultation conducted via phone

Consult duration	Regular counter	Kiosk
Mean (SD)	3.5 ± 2.1	2.6 ± 1.7
Range	1-10 min	1-10 min

Mean consult duration shorter at Kiosk vs Regular Counter ($p = 0.009$)

* Pharmacist includes Pharmacy Intern
Missing data = 0 Counter and 1 at Kiosk: Pharmacist did not record.

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Consultations: Day of Week and Time of Day Kiosk & Regular Counter Combined

Day	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total
# Consults	60	66	62	66	66	0	0	320
% of Total	18.8%	20.6%	19.4 %	20.6%	20.6%	0%	0%	

All consultations were performed on weekdays.

Only 3 consultations performed after hours (all for new prescriptions)

Pharmacist counseling available 24/7

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Counseling can occur before patient picks up prescription.

Pharmacist Assessments

- Ability to *build therapeutic relationship* with patient
- Ability to *establish a management plan* with patient
- Ability to *negotiate "safety netting" strategies* with patient

Scale

Not Able		Partially Able		Fully Able	Not Applicable
0	1	2	3	4	5

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Ability to *build therapeutic relationship* with patient

Not Able (0, 1) Partially Able (2, 3) Fully Able (4)

Score	Counter		Kiosk	
	Number	Percent	Number	Percent
0	0	0.0%	1	1.0%
1	1	0.7%	0	0.0%
2	4	2.8%	4	4.1%
3	79	56.0%	41	41.8%
4	57	40.4%	52	53.1%

Very similar ability to build therapeutic relationship.

N/A: Counter n=10, Kiosk n=71
Percentages may not add to 100% due to rounding error

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Ability to *establish a management plan* with patient

Not Able 0 1 Partially Able 2 3 Fully Able 4

Score	Counter		Kiosk	
	Number	Percent	Number	Percent
0	0	0.0%	2	3.6%
1	0	0.0%	1	1.8%
2	2	1.5%	3	5.4%
3	77	57.0%	31	55.4%
4	56	41.5%	19	33.9%

Very similar ability to establish management plan.

N/A: Counter n=16, Kiosk n=113
Percentages may not add to 100% due to rounding error

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Ability *negotiate "safety netting" strategies* with patient

Not Able 0 1 Partially Able 2 3 Fully Able 4

Score	Counter		Kiosk	
	Number	Percent	Number	Percent
0	0	0.0%	2	2.8%
1	0	0.0%	2	2.8%
2	2	1.5%	3	4.2%
3	71	54.6%	38	53.5%
4	57	43.8%	26	36.6%

Very similar ability to negotiate "safety netting".

N/A: Counter n=21, Kiosk n=98
Percentages may not add to 100% due to rounding error

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Conclusions

Majority of employees surveyed agreed

- More likely pick up medications if had easier access
- Would benefit from being able to pick up at work

Kiosk usage

- Fairly evenly divided among New, Refill and OTCs
- Majority Rxs (new & refill) picked up during pharmacy hours
  - However, kiosk used every hour of the day

Majority Kiosk users agreed

- Questions were answered regarding prescriptions
- If had questions knew how to call pharmacist

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Conclusions (continued)

Kiosk vs. Regular Counter

- No significant difference in mean RTS
- Mean time to pick up was about one day greater at Kiosk
- Percentage consultations with *no more questions* greater at Kiosk
- No appreciable difference in pharmacists' assessment of their ability to counsel

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Next Steps

- Q2 2017 Report Results to Board
  - April 18th, 2017 Enforcement Committee
  - May 3-4th, 2017 Board

  Continue Kiosk operation until regulation 1713 revised

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Questions?

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Appendices

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Pre-Kiosk Sharp Employee Survey

Subject:

Employee Prescription Delivery Service: Tell Us Your Thoughts!

Body of E-mail:

Sharp Rees-Stealy pharmacies are developing a way to deliver new and refill prescriptions for Sharp Metropolitan Medical Campus employees. The prescriptions would be available for convenient pick-up, any time or day at Sharp Memorial Hospital. Tell us your thoughts on this service by answering a one-minute survey.

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RTS: regular counter vs kiosk, by therapeutic class

Raw counts (not means due to small numbers)	**COUNTER (study period)**			**KIOSK**		
Therapeutic Class	Total Rx	Total RTS	RTS Rate (%)	Total Rx	Total RTS	RTS Rate (%)
				2		
Dermatological Agents	277	22	7.9	24	3	12.5
Diagnostic Aids	201	15	7.5	17	3	17.6
Other class	3711	173	4.7	385	25	6.5

Time from verify to pick up: regular counter vs kiosk, by therapeutic class

Mean ± SD	REGULAR COUNTER		KIOSK	
Therapeutic Class	Days	Hours	Days	Hours
Antibiotics*	1.1 ± 0.4	27.2 ± 9.1	4.0 ± 3.2	96.2 ± 77.2
Antifungals*	0.9 ± 1.2	20.6 ± 28.1	3.2 ± 2.4	77.6 ± 57.6
Antivirals	1.3 ± 1.1	32.0 ± 26.7	3.5 ± 3.6	83.9 ± 86.0
Antiparasitics	0.6 ± 0.3	14.1 ± 8.1	4.7 (one Rx)	113.8 (one Rx)
Contraceptives	1.8 ± 0.6	44.0 ± 14.8	2.6 ± 1.7	62.1 ± 40.7
Antidiabetics	1.8 ± 0.5	42.7 ± 11.8	2.2 ± 1.4	52.5 ± 33.4
Cardiovascular Agents*	1.8 ± 0.3	43.4 ± 6.0	3.2 ± 1.2	77.2 ± 28.9
Antihyperlipidemics	1.9 ± 0.4	45.1 ± 10.5	2.4 ± 1.0	57.6 ± 23.3
Cough & Cold Products	1.7 ± 0.6	40.4 ± 15.6	2.7 ± 2.7	63.8 ± 65.9
Respiratory Products*	1.6 ± 0.8	38.9 ± 19.5	3.2 ± 2.1	75.7 ± 51.0
Antidepressants	2.3 ± 0.6	56.7 ± 15.3	2.5 ± 0.9	60.6 ± 22.7
Anticoagulants*	1.7 ± 0.9	40.8 ± 21.9	6.6 ± 2.1	157.9 ± 50.1
Dermatological Agents*	2.2 ± 0.7	52.5 ± 17.7	4.9 ± 3.6	118.5 ± 85.8
Diagnostic Aids	3.0 ± 1.9	71.9 ± 45.9	2.6 ± 3.4	61.3 ± 81.5
Other class*	1.7 ± 0.2	40.3 ± 5.2	3.2 ± 2.1	74.6 ± 14.7

* = $p \leq 0.05$ Means based on # of months the class was dispensed

Counseling Log

Patient has: (write in number) _____ New Rx _____ Refill Rx	**Introduction** (Build a Relationship)	**Action** (Incorporate Patient's Understanding)	**Closing** (Safety Net Strategy)
Call day & time: **Call duration:** **Consult:** (check one) ___Counter for regular patient ___Phone for regular patient ___ Phone for kiosk patient **Consult Initiated by:** (circle one) Pharmacist Patient	1. Introduce self Yes or No 2. Explain role of pharmacist Yes or No 3. Confirm patient ID Yes or No 4. Discuss consult purpose: Yes or No • Structure Yes or No • Desired length Yes or No 5. Has the patient previously talked with a pharmacist about this/these medication(s)? Yes or No 6. Invite patient to discuss: Yes or No • Medication concerns Yes or No • Health related concerns Yes or No	1. What med is for: Yes or No 2. How to take med: Yes or No • Time of day Yes or No • Length of therapy Yes or No • Missed dose Yes or No 3. What to expect: Yes or No • Efficacy Yes or No • DDI Yes or No • S/E Yes or No 4. Invite patient to teach back: Yes or No • Patient understands Yes or No • Questions answered Yes or No 5. Lifestyle and prevention: Yes or No, N/A • Additional information Yes or No, N/A • Referral Yes or No, N/A	1. What to do if patient had difficulties following the plan Yes or No 2. Future appointment or contact provided: Yes or No 3. Opportunity to ask additional questions: Yes or No PHARMACIST ASK PATIENT Do you have any more questions about your medication(s) I haven't answered yet? (check No/Yes and write in number) _____ No _____ Yes Write in Number of Questions _____ What questions did the patient have?
Pharmacist-Assessment	Ability to *build therapeutic relationship* with patient N/A Not Able 0 1 2 3 4 Fully Able	Ability to *establish a management plan* with patient N/A Not Able 0 1 2 3 4 Fully Able	Ability to *negotiate "safety netting" strategies* with patient N/A Not Able 0 1 2 3 4 Fully Able

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ScriptCenter Kiosk Consultations *(study period)*

	Total prescriptions with a new Rx #, pharmacist released for pick up at ScriptCenter	New Rxs Requiring Counseling (including transferred) Counseling Provided	New Rxs Not Requiring Counseling (due to Sharp re-write with no changes) Counseling Not Required
March	49	28	21
April	37	17	20
May	41	28	13
June	42	22	20
July	45	32	13
August	63	33	30
September	55	23	32
October	49	16	33
November	59	38	21
December	58	18	40

- New prescription # (number) is ScriptCenter tracking method, some may not be “new” to pharmacy or patient.
- Pharmacist released Rx after required counseling provided.
- Total Rx’s released may not match number of pick-ups per month on previous slides due to pick-up occurring in month following release.

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Month	Types of Questions Asked at Kiosk
March	• Where do I pick up the medication? • How does the kiosk work? • Do I have additional refills on my medications? • Are you going to call me every time moving forward?
April	• Whether she can start taking it today as she is already on her period?
May	• Can I use both medications at the same time?
June	• Can you check to see if I have more refills than what the doctor charted? • Should I take all my meds with food?
July	• N/A
August	• I'm switching from Januvia, is it cheaper? • Can I take 2 doses of the antibiotic today? • Does it cause nervousness? • How/when to take food? • First time using the kiosk. Can you explain how to pay? • Is it the right prep my doctor ordered?

Duplicate questions not listed separately.

Month	Types of Questions Asked at Kiosk
September	• How many Rxs do I have? • Is it safe to take while pregnant? • Is it ok to take with Humira? • When should I start this medicine?
October	• Checking with increased dose of medication • Is it the same dose as my old medication? • Is it ok to take with probiotics?
November	• How many days supply is the antibiotic? • Can I have 3 months supply at a time? • What is my copay? • Will it interfere with my BP meds? • Can I get my other Rxs refilled?
December	• Do I have another pain medication to pick up? • Did my doctor authorize my birth control pills? • Do I need a prescription for ibuprofen 800 mg? • Did my doctor prescribe glucometer/strips/lancets? • Does the the kiosk have refrigeration? • Which one is the antibiotic? Is it a high dose? • How can I get my Rx transferred to you?

Duplicate questions not listed separately.

Month	Types of Questions Asked at Counter
May	• Hydration question • Patient is having surgery and wants to know start date (patient will call MD to double check) • Are side effects similar to prednisone? • MD stated that it is ok to use in both eyes. Is it ok? • What are the side effects? • Can I take this medication with food? • When to take the drug? • Is there a DDI between Venlafaxine and Ventolin? • Applying inside the anal area? Direction on label said not to apply inside anal area. Patient said he was told to apply inside anal area and will call and confirm with doctor. • Can I still take my morning high BP medication? • Patient needs to reschedule colonoscopy due to lack of diet education prior to procedure. • What food is ok to eat while on medication? • What other strengths does Zolpidem come in?

A sampling of counseling sessions at the Regular Counter was conducted.
Logs completed during 3 one week periods (May, June, December 2016)

Duplicate questions not listed separately.

Month	Types of Questions Asked at Counter
June	• When can I eat? • Reschedule Colonoscopy due to misinformation about diet restrictions • Does it have to be taken in the morning? • Does Simvastatin need to be stopped prior to colonoscopy? • Can I take it with Naproxen? • Can I still take my Calcium MVI before colonoscopy? • Can I still take my BP/DM meds before colonoscopy? • Can I take the medication with food? • Can I take my Blood pressure meds on the day of the colonoscopy? • How do I dispose of this if I am not taking it? • Do I need to stop my high cholesterol medications prior to colonoscopy?

A sampling of counseling sessions at the Regular Counter was conducted. Logs completed during 3 one week periods (May, June, December 2016)

Duplicate questions not listed separately.

Month	Types of Questions Asked at Counter
December	• Do I have another pain medication to pick up? • How to prepare medication? When to take medication? • Swish or gargle? If throat pain. • BP meds? • Is this medication refrigerated? Should this med be swallow or put on tongue? • Can this medication be taken with yogurt or probiotics? • Is it ok with breast feeding? • Does he have to take it with food? • Does it taste bad? • Can he take this medication now, before driving? • What do I do If I get nausea? • Should this be taken with food? • Is this med administered the same as Lantus? • Can I take the first two at once? • How much do I apply? Does it have to be refrigerated? • What time of day should I take it? • Can I suck on a lozenge while preparing for colonoscopy? • Does pt have to get up in the middle of the night to take the prescription? • Does it interact with Percocet? • Can I drink it all at once?

A sampling of counseling sessions at the Regular Counter was conducted. Logs completed during 3 one week periods (May, June, December 2016)

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Duplicate questions not listed separately.

§ 1713. Receipt and Delivery of Prescriptions and Prescription Medications.

(a) Except as otherwise provided in this Division, no licensee shall participate in any arrangement or agreement, whereby prescriptions, or prescription medications, may be left at, picked up from, accepted by, or delivered to any place not licensed as a retail pharmacy.

(b) A licensee may pick up prescriptions at the office or home of the prescriber or pick up or deliver prescriptions or prescription medications at the office of or a residence designated by the patient or at the hospital, institution, medical office or clinic at which the patient receives health care services. In addition, the Board may, in its sole discretion, waive application of subdivision (a) for good cause shown.

(c) A patient or the patient's agent may deposit a prescription in a secure container that is at the same address as the licensed pharmacy premises. The pharmacy shall be responsible for the security and confidentiality of the prescriptions deposited in the container.

(d) A pharmacy may use an automated delivery device to deliver previously dispensed prescription medications provided:

(1) Each patient using the device has chosen to use the device and signed a written consent form demonstrating his or her informed consent to do so.

(2) A pharmacist has determined that each patient using the device meets inclusion criteria for use of the device established by the pharmacy prior to delivery of prescription medication to the patient.

(3) The device has a means to identify each patient and only release that patient's prescription medications.

(4) The pharmacy does not use the device to deliver previously dispensed prescription medications to any patient if a pharmacist determines that such patient requires counseling as set forth in section 1707.2(a)(2).

(5) The pharmacy provides an immediate consultation with a pharmacist, either in-person or via telephone, upon the request of a patient.

(6) The device is located adjacent to the secure pharmacy area.

(7) The device is secure from access and removal by unauthorized individuals.

(8) The pharmacy is responsible for the prescription medications stored in the device.

(9) Any incident involving the device where a complaint, delivery error, or omission has occurred shall be reviewed as part of the pharmacy's quality assurance program mandated by Business and Professions Code section 4125.

(10) The pharmacy maintains written policies and procedures pertaining to the device as described in subdivision (e).

(e) Any pharmacy making use of an automated delivery device as permitted by subdivision (d) shall maintain, and on an annual basis review, written policies and procedures providing for:

(1) Maintaining the security of the automated delivery device and the dangerous drugs within the device.

(2) Determining and applying inclusion criteria regarding which medications are appropriate for placement in the device and for which patients, including when consultation is needed.

(3) Ensuring that patients are aware that consultation with a pharmacist is available for any prescription medication, including for those delivered via the automated delivery device.

(4) Describing the assignment of responsibilities to, and training of, pharmacy personnel regarding the maintenance and filing procedures for the automated delivery device.

(5) Orienting participating patients on use of the automated delivery device, notifying patients when expected prescription medications are not available in the device, and ensuring that patient use of the device does not interfere with delivery of prescription medications.

(6) Ensuring the delivery of medications to patients in the event the device is disabled or malfunctions.

(f) Written policies and procedures shall be maintained at least three years beyond the last use for an automated delivery device.

(g) For the purposes of this section only, “previously-dispensed prescription medications” are those prescription medications that do not trigger a non-discretionary duty to consult under section 1707.2(b)(1), because they have been previously dispensed to the patient by the pharmacy in the same dosage form, strength, and with the same written directions.

Note: Authority cited: Section 4005, 4075 and 4114, Business and Professions Code. Reference: Sections 4005, 4052, 4116 and 4117, Business and Professions Code.

Attachment 2

State of California

BUSINESS AND PROFESSIONS CODE

Section 4186

4186. (a) Automated drug delivery systems, as defined in subdivision (h), may be located in any clinic licensed by the board pursuant to Section 4180. If an automated drug delivery system is located in a clinic, the clinic shall develop and implement written policies and procedures to ensure safety, accuracy, accountability, security, patient confidentiality, and maintenance of the quality, potency, and purity of drugs. All policies and procedures shall be maintained at the location where the automated drug system is being used.

(b) Drugs shall be removed from the automated drug delivery system only upon authorization by a pharmacist after the pharmacist has reviewed the prescription and the patient's profile for potential contraindications and adverse drug reactions. Drugs removed from the automated drug delivery system shall be provided to the patient by a health professional licensed pursuant to this division.

(c) The stocking of an automated drug delivery system shall be performed by a pharmacist.

(d) Review of the drugs contained within, and the operation and maintenance of, the automated drug delivery system shall be the responsibility of the clinic. The review shall be conducted on a monthly basis by a pharmacist and shall include a physical inspection of the drugs in the automated drug delivery system, an inspection of the automated drug delivery system machine for cleanliness, and a review of all transaction records in order to verify the security and accountability of the system.

(e) The automated drug delivery system used at the clinic shall provide for patient consultation pursuant to Section 1707.2 of Title 16 of the California Code of Regulations with a pharmacist via a telecommunications link that has two-way audio and video.

(f) The pharmacist operating the automated drug delivery system shall be located in California.

(g) Drugs dispensed from the automated drug delivery system shall comply with the labeling requirements in Section 4076.

(h) For purposes of this section, an "automated drug delivery system" means a mechanical system controlled remotely by a pharmacist that performs operations or activities, other than compounding or administration, relative to the storage, dispensing, or distribution of prepackaged dangerous drugs or dangerous devices. An automated drug delivery system shall collect, control, and maintain all transaction information to accurately track the movement of drugs into and out of the system for security, accuracy, and accountability.

(Added by Stats. 2001, Ch. 310, Sec. 1. Effective January 1, 2002.)

State of California

HEALTH AND SAFETY CODE

Section 1261.6

1261.6. (a) (1) For purposes of this section and Section 1261.5, an "automated drug delivery system" means a mechanical system that performs operations or activities, other than compounding or administration, relative to the storage, dispensing, or distribution of drugs. An automated drug delivery system shall collect, control, and maintain all transaction information to accurately track the movement of drugs into and out of the system for security, accuracy, and accountability.

(2) For purposes of this section, "facility" means a health facility licensed pursuant to subdivision (c), (d), or (k), of Section 1250 that has an automated drug delivery system provided by a pharmacy.

(3) For purposes of this section, "pharmacy services" means the provision of both routine and emergency drugs and biologicals to meet the needs of the patient, as prescribed by a physician.

(b) Transaction information shall be made readily available in a written format for review and inspection by individuals authorized by law. These records shall be maintained in the facility for a minimum of three years.

(c) Individualized and specific access to automated drug delivery systems shall be limited to facility and contract personnel authorized by law to administer drugs.

(d) (1) The facility and the pharmacy shall develop and implement written policies and procedures to ensure safety, accuracy, accountability, security, patient confidentiality, and maintenance of the quality, potency, and purity of stored drugs. Policies and procedures shall define access to the automated drug delivery system and limits to access to equipment and drugs.

(2) All policies and procedures shall be maintained at the pharmacy operating the automated drug delivery system and the location where the automated drug delivery system is being used.

(e) When used as an emergency pharmaceutical supplies container, drugs removed from the automated drug delivery system shall be limited to the following:

(1) A new drug order given by a prescriber for a patient of the facility for administration prior to the next scheduled delivery from the pharmacy, or 72 hours, whichever is less. The drugs shall be retrieved only upon authorization by a pharmacist and after the pharmacist has reviewed the prescriber's order and the patient's profile for potential contraindications and adverse drug reactions.

(2) Drugs that a prescriber has ordered for a patient on an as-needed basis, if the utilization and retrieval of those drugs are subject to ongoing review by a pharmacist.

(3) Drugs designed by the patient care policy committee or pharmaceutical service committee of the facility as emergency drugs or acute onset drugs. These drugs may

be retrieved from an automated drug delivery system pursuant to the order of a prescriber for emergency or immediate administration to a patient of the facility. Within 48 hours after retrieval under this paragraph, the case shall be reviewed by a pharmacist.

(f) When used to provide pharmacy services pursuant to Section 4119.1 of the Business and Professions Code, the automated drug delivery system shall be subject to all of the following requirements:

(1) Drugs removed from the automated drug delivery system for administration to a patient shall be in properly labeled units of administration containers or packages.

(2) A pharmacist shall review and approve all orders prior to a drug being removed from the automated drug delivery system for administration to a patient. The pharmacist shall review the prescriber's order and the patient's profile for potential contraindications and adverse drug reactions.

(3) The pharmacy providing services to the facility pursuant to Section 4119.1 of the Business and Professions Code shall control access to the drugs stored in the automated drug delivery system.

(4) Access to the automated drug delivery system shall be controlled and tracked using an identification or password system or biosensor.

(5) The automated drug delivery system shall make a complete and accurate record of all transactions that will include all users accessing the system and all drugs added to, or removed from, the system.

(6) After the pharmacist reviews the prescriber's order, access by licensed personnel to the automated drug delivery system shall be limited only to drugs ordered by the prescriber and reviewed by the pharmacist and that are specific to the patient. When the prescriber's order requires a dosage variation of the same drug, licensed personnel shall have access to the drug ordered for that scheduled time of administration.

(7) (A) Systems that allow licensed personnel to have access to multiple drugs and are not patient specific in their design, shall be allowed under this subdivision if those systems have electronic and mechanical safeguards in place to ensure that the drugs delivered to the patient are specific to that patient. Each facility using such an automated drug system shall notify the department in writing prior to the utilization of the system. The notification submitted to the department pursuant to this paragraph shall include, but is not limited to, information regarding system design, personnel with system access, and policies and procedures covering staff training, storage, and security, and the facility's administration of these types of systems.

(B) As part of its routine oversight of these facilities, the department shall review a facility's medication training, storage, and security, and its administration procedures related to its use of an automated drug delivery system to ensure that adequate staff training and safeguards are in place to make sure that the drugs delivered are appropriate for the patient. If the department determines that a facility is not in compliance with this section, the department may revoke its authorization to use automated drug delivery systems granted under subparagraph (A).

(g) The stocking of an automated drug delivery system shall be performed by a pharmacist. If the automated drug delivery system utilizes removable pockets, cards,

drawers, similar technology, or unit of use or single dose containers as defined by the United States Pharmacopoeia, the stocking system may be done outside of the facility and be delivered to the facility if all of the following conditions are met:

(1) The task of placing drugs into the removable pockets, cards, drawers, or unit of use or single dose containers is performed by a pharmacist, or by an intern pharmacist or a pharmacy technician working under the direct supervision of a pharmacist.

(2) The removable pockets, cards, drawers, or unit of use or single dose containers are transported between the pharmacy and the facility in a secure tamper-evident container.

(3) The facility, in conjunction with the pharmacy, has developed policies and procedures to ensure that the removable pockets, cards, drawers, or unit of use or single dose containers are properly placed into the automated drug delivery system.

(h) Review of the drugs contained within, and the operation and maintenance of, the automated drug delivery system shall be done in accordance with law and shall be the responsibility of the pharmacy. The review shall be conducted on a monthly basis by a pharmacist and shall include a physical inspection of the drugs in the automated drug delivery system, an inspection of the automated drug delivery system machine for cleanliness, and a review of all transaction records in order to verify the security and accountability of the system.

(i) Drugs dispensed from an automated drug delivery system that meets the requirements of this section shall not be subject to the labeling requirements of Section 4076 of the Business and Professions Code or Section 111480 of this code if the drugs to be placed into the automated drug delivery system are in unit dose packaging or unit of use and if the information required by Section 4076 of the Business and Professions Code and Section 111480 of this code is readily available at the time of drug administration. For purposes of this section, unit dose packaging includes blister pack cards.

(Amended by Stats. 2016, Ch. 484, Sec. 54. (SB 1193) Effective January 1, 2017.)

State Board of Pharmacy- Enforcement Committee
Review- Pharmacy Automation Technology

Background: Multiple pharmacy automation vendors provided presentations at the February 17, 2017 Board meeting. These vendors provided an overview of existing technology, and dispensing/restocking workflow for their respective products. Each vendor also requested modification of existing pharmacy law to accommodate use of their technology. The Enforcement Committee was asked to review these requests and provide recommendations to the full Board of any changes needed to the law to enable technology that is believed to be safe, accurate, minimizes ability for drug diversion, and improves patient access.

In an effort to provide a framework for this discussion, a table was prepared that outlines the various technologies presented (so far) as well as policy discussion items for each.

CATEGORY 1: Medication dispensing technology that is accessed by Nursing at the remote site to obtain medications that are then administered to the patient at the remote site. Examples of remote sites include skilled nursing facilities and correctional settings.

Category I Technology	Description	Medication dispensing	Replenishment of medications	Transport of Medication	Who performs replenishment	Policy discussion items
A1	Automated Dispensing Cabinets- hosted by pharmacy not physically located at remote site	Nurse at remote site	Host Pharmacy replenishes medication in unit dose packets. Stock levels and reports are accessed from the pharmacy location to facilitate replenishment	Sealed tamper-proof sealed plastic container with a chip that identifies the canister. Container will not allow placement into technology if tampered with.	Various workflows described: Nurse at remote site Pharmacist physically places into ADC Pharmacy technician, under pharmacist supervision, physically places into ADC	• Is the medication stored in the remote site ADC part of the pharmacy inventory? If the licensed clinic owns the ADC, what role does pharmacy play in restocking? • Who should be allowed to place the sealed tamper-proof plastic container into the ADC? Is Nursing allowed to place the tamper-proof canister into the ADC after receipt from the pharmacy? • If controlled drugs are supplied, does this require a DEA 222 form for each restock? • Should the remote site be licensed?
A2	Automated Dispensing Cabinets- hosted by pharmacy not	Nurse at remote site	Host Pharmacy replenishes medication in unit dose packets. Stock levels and reports	Sealed medication delivery bags are utilized to transport medication	Various workflows described: Nurse at remote site Pharmacist	Same as A1 above, plus: • Are there concerns for drug diversion due to less than secure transport workflow? • How will pharmacy be assured that all medication arrived at location?

	physically located at remote site		are accessed from the pharmacy location to facilitate replenishment	from pharmacy to remote site. May or may not have tamper proof seal; no plastic container. Remote site replenishment involves placement of individual doses into ADC cell manually (no canister with chip)	physically places into ADC Pharmacy technician, under pharmacist supervision, physically places into ADC	
B1	Medication Canisters with patient-specific packaging that is performed at the remote site	Nurse at remote site-typically in 24-hour patient-specific plastic packets for oral solids	Host pharmacy replenishes drug-specific oral solid canisters that are placed into the device at the remote site. Stock levels and reports are accessed from the pharmacy location to facilitate replenishment	Sealed tamper-proof sealed plastic container with a chip that identifies the canister. Container will not allow placement into technology if tampered with.	Nurse physically places the drug-specific oral solid canister into the device.	• Is the medication stored at the remote site part of the pharmacy inventory? If the licensed clinic owns the technology, what role does pharmacy play in restocking? • Who should be allowed to place the sealed tamper-proof plastic container into the device? Is Nursing allowed to place the tamper-proof canister into the device after receipt from the pharmacy? • If controlled drugs are supplied, does this require a DEA 222 form for each restock? • Should the remote site be licensed?

CATEGORY 2: Medication dispensing technology that is accessed by healthcare providers in order to provide the patient at the remote site to access medications for at home self-administration

Category I Technology	Description	Medication dispensing	Replenishment of medications	Transport of Medication	Who performs replenishment	Policy discussion items
A1	Robot that dispenses medication through	Staff at remote site. Robot labels the patient	Host Pharmacy replenishes medication in drug specific	Various	Staff at remote site	• Is the medication stored in the remote site part of the pharmacy inventory? If the licensed clinic owns the technology, what role does pharmacy play in restocking? • Who should be allowed to place the containers into the

	direct real-time link with pharmacist	medication containers per information input by remote pharmacist.	containers. Stock levels and reports are accessed from the pharmacy location to facilitate replenishment			technology? Is Nursing allowed to place the medication after receipt from the pharmacy? • Some vendors cited the use of a wholesaler to replenish the inventory in the automated device. Should the board allow wholesalers to receive and restock medication on behalf of a pharmacy? • If controlled drugs are supplied, does this require a DEA 222 form for each restock? • Should the remote site be licensed? • How is patient counseling performed? Is the patient interaction conducive to patient teaching (screen size, technology, etc.) Is patient counseling always provided (some state only upon patient request) • Does the label meet state label requirements? • How is drug diversion detected if transport does not include tamper-proof sealed canisters? How is drug diversion detected from a wholesaler or other non-pharmacy replenishment?
A2	Robot that dispenses medication through direct real-time link with pharmacistq	Staff at remote site. Staff must assemble medication container, and label printed separately and affix the label to the container at remote site	Host Pharmacy replenishes medication in drug specific containers. Stock levels and reports are accessed from the pharmacy location to facilitate replenishment	Various	Staff at remote site	All of the above plus: • Are there any patient safety concerns with someone other than a pharmacist affixing a medication label?
B	Technology that dispenses pharmacy-filled medications to facilitate patient access	Performed within the pharmacy	Host pharmacy places filled patient-specific patient medication bags into technology to facilitate patient pick-up from a remote location.	Pharmacy	Pharmacy	Current pilot ongoing with UCSD; awaiting pilot results. • How is patient counseling performed? • How is drug diversion detected? • Should the remote site be licensed?

Attachment 3

1715.65. Inventory Reconciliation Report of Controlled Substances

(a) Every pharmacy, and every clinic licensed under sections 4180 or 4190, shall perform periodic inventory and inventory reconciliation functions to detect and prevent the loss of controlled substances.

(b) The pharmacist-in-charge of a pharmacy or consultant pharmacist for a clinic shall review all inventory and inventory reconciliation reports taken, and establish and maintain secure methods to prevent losses of controlled drugs. Written policies and procedures shall be developed for performing the inventory reconciliation reports required by this section.

(c) A pharmacy or clinic shall compile an ~~Inventory Reconciliation Report~~ inventory reconciliation of all Schedule II controlled substances at least every three months. This compilation shall require:

(1) A physical count, not an estimate, of all quantities of Schedule II controlled substances. The biennial inventory of controlled substances required by federal law may serve as one of the mandated inventories under this section in the year where the federal biennial inventory is performed, provided the biennial inventory was taken no more than three months from the last inventory required by this section;

(2) A review of all acquisitions and dispositions of Schedule II controlled substances since the last ;

(3) A comparison of (1) and (2) to determine if there are any variances; and

(4) All records used to compile each Inventory Reconciliation Report shall be maintained in the pharmacy or clinic for at least three years in a readily retrievable form.

(d) A pharmacy or clinic shall report in writing identified ~~l~~losses and causes ~~shall be identified in writing and reported~~ to the board ~~and, when appropriate, to the Drug Enforcement Administration~~within 30 days unless the cause of the loss is theft, diversion, or self-use in which case the report shall be made within 14 days. If the pharmacy or clinic is unable to identify the cause of the loss, further investigation shall be undertaken to identify the cause and necessary to prevent additional losses of controlled substances.

(e) ~~Likely Possible causes of overages shall be identified in writing and incorporated into the~~ The Inventory Reconciliation Report shall be dated and signed by the individual(s) performing the inventory, and countersigned by the pharmacist-in-charge or professional director if a clinic and be readily retrievable in the pharmacy or clinic for three years. A countersignature is not required if the pharmacist-in-charge or professional director personally completed the inventory reconciliation report.

(~~e~~f) A new pharmacist-in-charge of a pharmacy shall complete an inventory reconciliation report ~~as~~ as identified in subdivision (c). Whenever possible an outgoing pharmacist-in-charge should complete an inventory reconciliation report as required in subdivision (c).

(~~f~~g) For inpatient hospital pharmacies, a separate quarterly shall be required for Schedule II controlled substances stored within the pharmacy and for each pharmacy satellite location.

(~~g~~h) The pharmacist-in-charge of an inpatient hospital pharmacy or of a pharmacy servicing onsite or offsite automated drug delivery systems shall ensure that:

(1) All controlled substances added to an automated drug delivery system are accounted for;
(2) Access to automated drug delivery systems is limited to authorized facility personnel;
(3) An ongoing evaluation of discrepancies or unusual access associated with controlled substances is performed; and
(4) Confirmed losses of controlled substances are reported to the board~~; and~~.

~~5) A pharmacy or clinic identifying losses of controlled drugs but unable to identify the cause within 30 days shall take additional steps to identify the origin of the losses and improve security of controlled substance access to prevent losses.~~

State of California

BUSINESS AND PROFESSIONS CODE

Section 4116

4116. (a) No person other than a pharmacist, an intern pharmacist, an authorized officer of the law, or a person authorized to prescribe shall be permitted in that area, place, or premises described in the license issued by the board wherein controlled substances or dangerous drugs or dangerous devices are stored, possessed, prepared, manufactured, derived, compounded, dispensed, or repackaged. However, a pharmacist shall be responsible for any individual who enters the pharmacy for the purposes of receiving consultation from the pharmacist or performing clerical, inventory control, housekeeping, delivery, maintenance, or similar functions relating to the pharmacy if the pharmacist remains present in the pharmacy during all times as the authorized individual is present.

(b) (1) The board may, by regulation, establish reasonable security measures consistent with this section in order to prevent unauthorized persons from gaining access to the area, place, or premises or to the controlled substances or dangerous drugs or dangerous devices therein.

(2) The board shall, by regulation, establish conditions for the temporary absence of a pharmacist for breaks and lunch periods pursuant to Section 512 of the Labor Code and the orders of the Industrial Welfare Commission without closing the pharmacy and removing authorized personnel from the pharmacy. These conditions shall ensure the security of the pharmacy and its operations during the temporary absence of the pharmacist and shall allow, at the discretion of the pharmacist, nonpharmacist personnel to remain and perform any lawful activities during the pharmacist's temporary absence.

(Amended by Stats. 1999, Ch. 900, Sec. 4. Effective October 10, 1999.)

State of California

BUSINESS AND PROFESSIONS CODE

Section 4117

4117. No person other than a pharmacist, an intern pharmacist, a pharmacy technician, an authorized officer of the law, a person authorized to prescribe, a registered nurse, a licensed vocational nurse, a person who enters the pharmacy for purposes of receiving consultation from a pharmacist, or a person authorized by the pharmacist in charge to perform clerical, inventory control, housekeeping, delivery, maintenance, or similar functions relating to the pharmacy shall be permitted in that area, place, or premises described in the license issued by the board to a licensed hospital wherein controlled substances, dangerous drugs, or dangerous devices are stored, possessed, prepared, manufactured, derived, compounded, dispensed, or repackaged.

(Amended by Stats. 1997, Ch. 549, Sec. 69. Effective January 1, 1998.)

16 CCR § 1715.6
§ 1715.6. Reporting Drug Loss.

The owner shall report to the Board within thirty (30) days of discovery of any loss of the controlled substances, including their amounts and strengths.

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

Attachment 4

CURES, Prescription Drug Abuse and Overdose Prevention; What a Pharmacist Needs to Know

Joint Training by the California State Board of Pharmacy, UC San Diego Skaggs School of Pharmacy and U.S. Drug Enforcement Administration

UC San Diego
Skaggs School of Pharmacy and Pharmaceutical Sciences

CALIFORNIA STATE BOARD OF PHARMACY
BE AWARE AND TAKE CARE: Talk to your pharmacist!

Rx Drug Abuse Task Force – San Diego County

March 11, 2017

UCSD Skaggs School of Pharmacy
Pharmaceutical Sciences Building, 873
9500 Gilman Drive
(Off Osler Lane at Gilman Drive)
La Jolla, CA 92093
See Attached Map

Pharmacists will be awarded 6 hours of CE credit for attending the session. An additional 1 hour of CE can be earned at the end of the day that meets the requirements of the State's Pharmacist Protocol to Provide Naloxone (for a total of 7 hours CE).

This is a FREE event. Space is limited; pre-registration is strongly encouraged. To register email your full name and license number (if applicable) to registration@dca.ca.gov. If you have questions please contact Laura Hendricks at laura.hendricks@dca.ca.gov or (916) 574-7918.

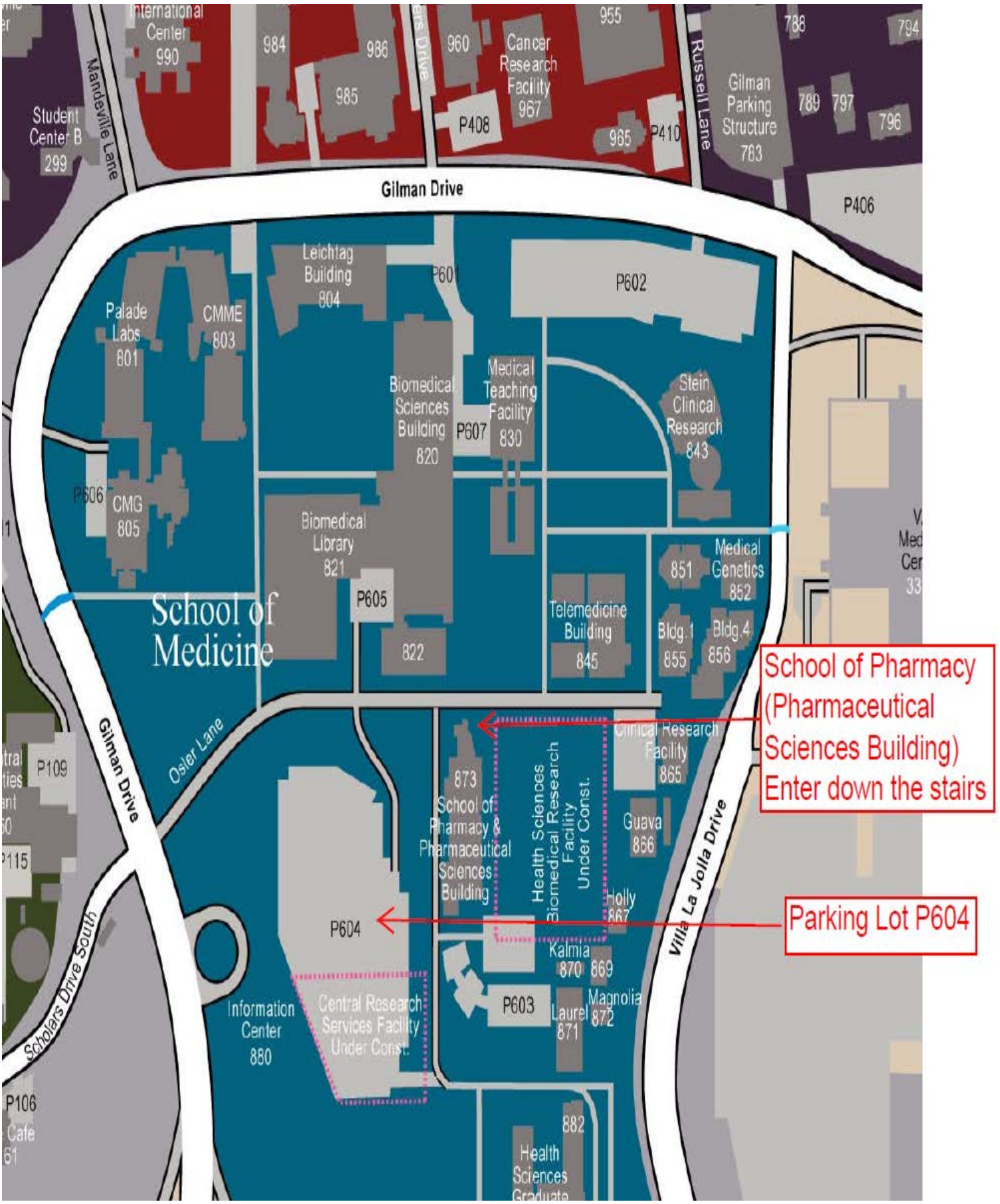
March 11, 2017
Agenda

Space is Limited, Registration Strongly Encouraged -See First Page for Registration Instructions

Location: UCSD Skaggs School of Pharmacy
Pharmaceutical Sciences Building, 873
9500 Gilman Drive
La Jolla, CA 92093
See attached map

7:30 a.m. - 8:15 a.m.	**Registration**
8:15 a.m. - 8:30 a.m.	**Welcoming Remarks** *Board of Pharmacy, DEA, UCSD*
8:30 a.m. - 10:00 a.m.	**Law Enforcement Trends, Drugs of Abuse and Reporting Procedures for Controlled Substances Losses** *DEA*
10:00 a.m. - 10:15 a.m.	**Break**
10:15 a.m. - 10:45 p.m.	**Preventing Drug Thefts and Diversion from Pharmacies** *Board of Pharmacy*
10:45 a.m. - 11:45 a.m.	**Corresponding Responsibility & Red Flags** *Board of Pharmacy*
11:45 a.m. - 12:15 p.m.	**Drug Take Back Process in California** *Board of Pharmacy*
12:15 p.m. - 1:15 p.m.	**Lunch Break**
1:15 p.m. - 1:45 p.m.	**California's Prescription Drug Monitoring Program -- CURES** *Board of Pharmacy, UCSD*
1:45 p.m. - 2:15 p.m.	**How to Prepare for Pharmacy Inspections by the Board of Pharmacy** *Board of Pharmacy*
2:15 p.m. - 2:45 p.m.	**How to Prepare for a DEA Inspection and Compliance with the Combat Methamphetamine Enforcement Act** *DEA*
2:45 p.m. – 3:00 p.m.	**Break**
3:00 p.m. - 3:30 p.m.	**E-Prescribing at UCSD** *UCSD*
3:30 p.m. - 4:45 p.m.	**Training for California Pharmacists to Provide Naloxone Pursuant to the State's Pharmacist Protocol** *UCSD*
4:45 p.m.	**Wrap Up**

Meeting location provided by UC San Diego, Skaggs School of Pharmacy


School of Pharmacy (Pharmaceutical Sciences Building) Enter down the stairs
Parking Lot P604
School of Medicine
Gilman Drive
Osler Lane
Villa La Jolla Drive
Scholars Drive South
Mandeville Lane
Russell Lane
International Center 990
Student Center B 299
984
986
985
960
Cancer Research Facility 967
955
P408
965
P410
788
794
Gilman Parking Structure 783
789
797
796
P406
Leichtag Building 804
P601
P602
Palade Labs 801
CMME 803
Biomedical Sciences Building 820
P607
Medical Teaching Facility 830
Stein Clinical Research 843
P606
CMG 805
Biomedical Library 821
P605
822
Telemedicine Building 845
851
Medical Genetics 852
Bldg. 1 855
Bldg. 4 856
873 School of Pharmacy & Pharmaceutical Sciences Building
Health Sciences Biomedical Research Facility Under Const.
Clinical Research Facility 865
Guava 866
Holly 867
P604
Kalmia 870
869
P603
Laurel 871
Magnolia 872
Information Center 880
Central Research Services Facility Under Const.
882
Health Sciences Graduate
P109
P115
P106
Cafe

Attachment 5

California State Board of Pharmacy
1625 N. Market Blvd, N219, Sacramento, CA 95834
Phone: (916) 574-7900
Fax: (916) 574-8618
www.pharmacy.ca.gov

Item 1111-001-0767 - Department of Consumer Affairs
Board of Pharmacy
Combatting Prescription Drug Abuse

As part of its oversight role, the Legislative Analyst's Office (LAO) instructed the California State Board of Pharmacy (Board) to provide a report to the fiscal subcommittees regarding its efforts to combat prescription drug abuse. Specifically, the Board was asked to provide a supplemental report to the 2016-17 Budget and provide information on the following:

1. Narrative description of the preceding year's activities related to combatting prescription drug abuse.
2. Funding and expenses information including the budgeted, allocated and expended money.
3. Number of positions and responsibilities.
4. Number of cases and disposition of cases referred to the Office of the Attorney General (AG) as a result of a case opened from a coroner report.
5. Number of hours spent combating prescription drug abuse, including separately identifying the total number of hours spent reviewing coroners reports and submitting public records requests to obtain the reports.

This report summarizes the Board's efforts to combat prescription drug abuse.

1. Description of the preceding year's activities related to combatting prescription drug abuse.
During the budget process last year, the LAO requested a report be provided with specific information. This request was made on or about May 1, 2016. It was upon this request that the Board began collecting data specific to the report. As such the reporting period is between May 1, 2016 and February 28, 2017, the Board initiated 167 investigations. During this timeframe the Board completed 147 investigations. The investigations substantiated violations of pharmacy law in 82% of the cases, including 66 investigations that resulted in the issuance of a citation, 37 that resulted in the issuance of a letter of admonishment, and 18 that resulted in referral to the AG.

As part of its proactive approach, the Board reviews information from various sources to determine if an investigation may be appropriate. The completed investigations during this reporting period were initiated based on a number of different activities including:

1. Reporting of sales data from wholesalers to pharmacies.
2. CURES data looking for excessive furnishing aggregate volumes by a single pharmacy.
3. CURES data looking for popular prescription drug combinations of abuse.
4. CURES data looking for red flags of prescription drug abuse including clinical irregularities, geographic irregularities, and signs of over prescribing and over dispensing.
5. CURES system alerts identifying anomalies in dispensing data by a single pharmacy.
6. Prescriptions written for medications outside of a practitioner's scope of practice.
7. Review of CURES for reporting compliance.

<u>Summary of Some Investigations</u>

One case completed during this timeframe was initiated after review and analysis of sales reports from a wholesaler. The Board's investigation revealed significant unaccounted for drug shortages

including over 32,000 tablets of hydrocodone/acetaminophen; almost 11,00 tablets of alprazolam; about 8,700 tablets of carisoprodol; and almost 1,500 ml of promethazine/codeine. (The street value for these missing medications is well over $200,000.) The matter was referred to the AG and the administrative hearing is scheduled for mid-September 2017.

In another case the Board initiated an investigation after review and analysis of CURES data showed red flags. The investigation revealed respondents failed to exercise corresponding responsibility and ignored many of the warning signs a pharmacy should consider prior to dispensing a controlled substance. Specifically, review of the data and investigation found that respondents dispensed prescriptions written by a prescriber whose profile revealed that 98% of the prescriptions were paid for with cash, 96% of the prescriptions written by the prescriber were written for controlled substances and nearly all the patients' prescriptions were for the highest tablet strength of oxycodone. This matter was referred to the AG and the administrative hearing is scheduled for June 2017.

In another case, the Board initiated an investigation after an inspection of a pharmacy revealed violations of pharmacy law including a failure to report to CURES. As part of the investigation, analysis of records and CURES data was completed which revealed that the respondents were dispensing controlled substances pursuant to fraudulent prescriptions and that the pharmacy was negligent in excessively furnishing controlled substances. This matter was referred to the AG. The accusation was on March 18, 2017.

2. Total amount of funding budgeted, allocated, and expended

Reporting Period May 2016 – February 2017	**Budgeted****	**Expended**
Staffing and Operating Expenses	$1,261,000	$1,221,223*
AG Costs	N/A	$167,957
Total	$1,261,000	$1,389,180

***FY 2015-16 (May 2016 - June 2016) - $302,816 salary included**
FY 2016-17 (July 2016 - Jan 2017) - $918,407
**** Budget for FY 2016-17**

3. Number of positions and their responsibilities

The Board acquired one Supervising Inspector position; five Inspector positions, one Research Program Specialist (RPS) position, and one Associate Governmental Program Analyst (AGPA) position through BCP #1110-27 in Fiscal Year 2014-15. General duties of the positions are detailed below.

Supervising Inspector:

- Reviewing cases for assignment and closure
- Developing investigation plans and assessments
- Conducting investigations and inspections
- Reviewing submitted investigations
- Presiding over citation and fine appeals
- Supervision duties

- Training Prescription Drug Abuse Team inspector staff
- Administrative duties
- Collaborating with other State and Federal Regulatory Agencies

Inspector:

- Reviewing cases and data from the Controlled Substance Utilization Review and Evaluation System (CURES)
- Conducting inspections
- Conducting investigations
- Testifying in Administrative Hearings

RPS:

- Requesting dispensing data from licensees (California Code of Regulations (CCR) section 1782)
- Evaluating information obtained in CCR 1782 reports
- Running CURES reports based on CCR 1782 data
- Evaluating CURES reports for trends
- Developing trend reports for prescription drugs abused
- Presenting findings to the committee and Board
- Performing statistical analysis on CURES
- Running CURES compliance reports
- Serving as a CURES liaison with the Department of Justice (DOJ)

AGPA:

- Requesting data derived from coroner's reports related to drug overdoses *
- Utilizing data from coroner's reports to initiate CURES reports
- Running subsequent CURES reports based on investigations initiated
- Opening investigations relating to prescription drug abuse
- Routing cases relating to prescription drug abuse
- Closing cases relating to prescription drug abuse
- Referring cases to Attorney General's (AG's) Office
- Referring cases to the Enforcement Unit to issue citations and fines

*This task was reassigned from the RPS duties.

4. Number of cases and disposition of those cases referred to the AG for prosecution that were a direct result from findings from a coroner's report.

One of the sources the Board has used to identify pharmacies that may be violating their corresponding responsibility is through review of decedent reports from counties. The Board requests a list of decedents with specific parameters and upon receipt a cursory review of the list is completed to identify if, based on the information, actions by a board licensee could have played a role in the patient's death. In such instances, the Board will generate a patient report from the CURES system to identify what pharmacy or pharmacies the patient used. After the pharmacy report is generated, analysis is completed to assess if the pharmacy data contains any red flags that warrant further review at which point an investigation may be initiated.

No investigations initiated directly from a finding from a coroner's report have been referred to the AG for prosecution. The Board currently has seven investigations pending.

5. Hours Spent Investigation Prescription Drug Abuse

Between May 1, 2016 and February 28, 2017 Board staff spent 6,978.75 hours on efforts to combat prescription drug abuse. The primary time spent is categorized below:

Task	Time
Opening/Routing Investigations	225 hours
Generating CURES Reports	360 hours
Data Analysis (not part of Investigation)	357 hours
Investigations	6036.75 hours

Notes: RPS position vacant from June 2016 until September 2016. AGPA position vacated January 15, 2017. Also, the time reported above does not include any administrative time such as meetings, training, etc.

The number of hours spent submitting a public records act request for coroner report and reviewing the report is two hours during this time period with an additional 187 hours spent generating and reviewing CURES reports for decedents. Based on this review and analysis of pharmacy CURES data, the Board initiated seven investigations during this reporting time period. Below is brief synopsis of allegations of two such investigations:

1. A review of a patient activity report identified a suspect pharmacy. Analysis of the pharmacy's overall dispensing data in CURES for controlled substances determined nearly 50% of the controlled substances were paid for without prescription insurance. A review of the prescribers with the most controlled drugs dispensed revealed three of the top doctors have pending accusations, criminal convictions and/or revoked licenses. The top doctor showed a prescribing pattern of maximum strength opioid and benzodiazepine drugs with no upward titration. It was based on these red flags for potential abuse that the Board initiated an investigation.

2. Review of a patient activity report identified a suspect pharmacy. An examination of pharmacy's CURES data, dispensing data, and prescription documents determined controlled drugs were dispensed earlier than directed by the doctor. This occurred repeatedly and consistently for some patients. For example, with one patient, in aggregate, the pharmacy dispensed 390 days' worth of a controlled drug to the patient over 297 days. In turn, approximately a three month supply surplus was received by the patient. Patients that receive controlled substance drugs ahead of schedule are exposed to the risk of taking higher doses than prescribed. The pharmacy received a citation for violations related to the dispensing of excess controlled drugs.

In addition, the Board sometimes receives information of a patient death from a different source. For example, a pharmacist notified the Board he declined to fill a prescription for an opioid drug based on his professional judgment that the patient was an opiate naïve patient (an opiate naïve patient is one that does not chronically receive opioid analgesics on a daily basis and has not built up a tolerance to opioids). The pharmacist considered the dose to be too high and attempted consultation with the

prescriber. The patient requested the prescription back. CURES data showed the patient filled the prescription a few days later at a different pharmacy. The day after filling the prescription, the patient died. The coroner's report showed mixed drug intoxication including the prescription filled.

Attachment 6

Compounding Data

Compounding Committee 4/18/17

Christine Acosta PharmD

Sterile Compounding Licenses

As of 4/4/17

- 733 sites with 876 LSCs
  - 325 PHYs with 325 LSCs
  - 402 HSP with 545 LSCs
  - 6 LCF with 6 LSCs
- NSC: 90

Inspections conducted

7/1/16 to 1/31/17:

- Total: 647
  - Compound New: 45
  - Compound Renewal: 602

Inspections conducted

7/1/16 to 2/28/17:

- Totals: 647 inspections
  - 882 corrections issued at 326 locations
  - 94 violations issued at 35 locations

Inspections conducted

7/1/16 to 2/28/17: Total: 647 inspections

- Compound New: 45 inspections
  - 36 corrections issued at 15 locations
  - 7 violations issued at 1 location
- Compound Renewal: 602 inspections
  - 846 corrections issued at 311 locations
  - 87 violations issued at 34 locations

Inspections conducted

7/1/16 to 2/28/17: Overview

- 326 locations issued corrections /647 inspections conducted:
  - ~ 50% of locations inspected received a correction
- 35 locations issued violations /647 inspection conducted:
  - ~ 5% of locations inspected received a violation

Top Corrections and Violations

- 129 (36%) issued for noncompliance with facility and equipment standards
  - 1751.4
  - 56 (16%) issued for not cleaning compliantly or not cleaning on the required schedule.
    - 1751.4(d)

Front Grate of a BSC

Front Grate of BSC

Bottom of the deck in a LFH

Hand washing sink

Tray for an autoclave

Top Correction and Violations

- 93 (26%) issued for noncompliance with records of compounding limitations and requirements
  - 1735.2
  - 57 (16%) issued for noncompliance with master formula requirements
    - 1735.2(d) and 1735.2(e)
  - 18 issued for noncompliance with BUD assignment- NEW
    - 1735.2(i)

Top Correction and Violations

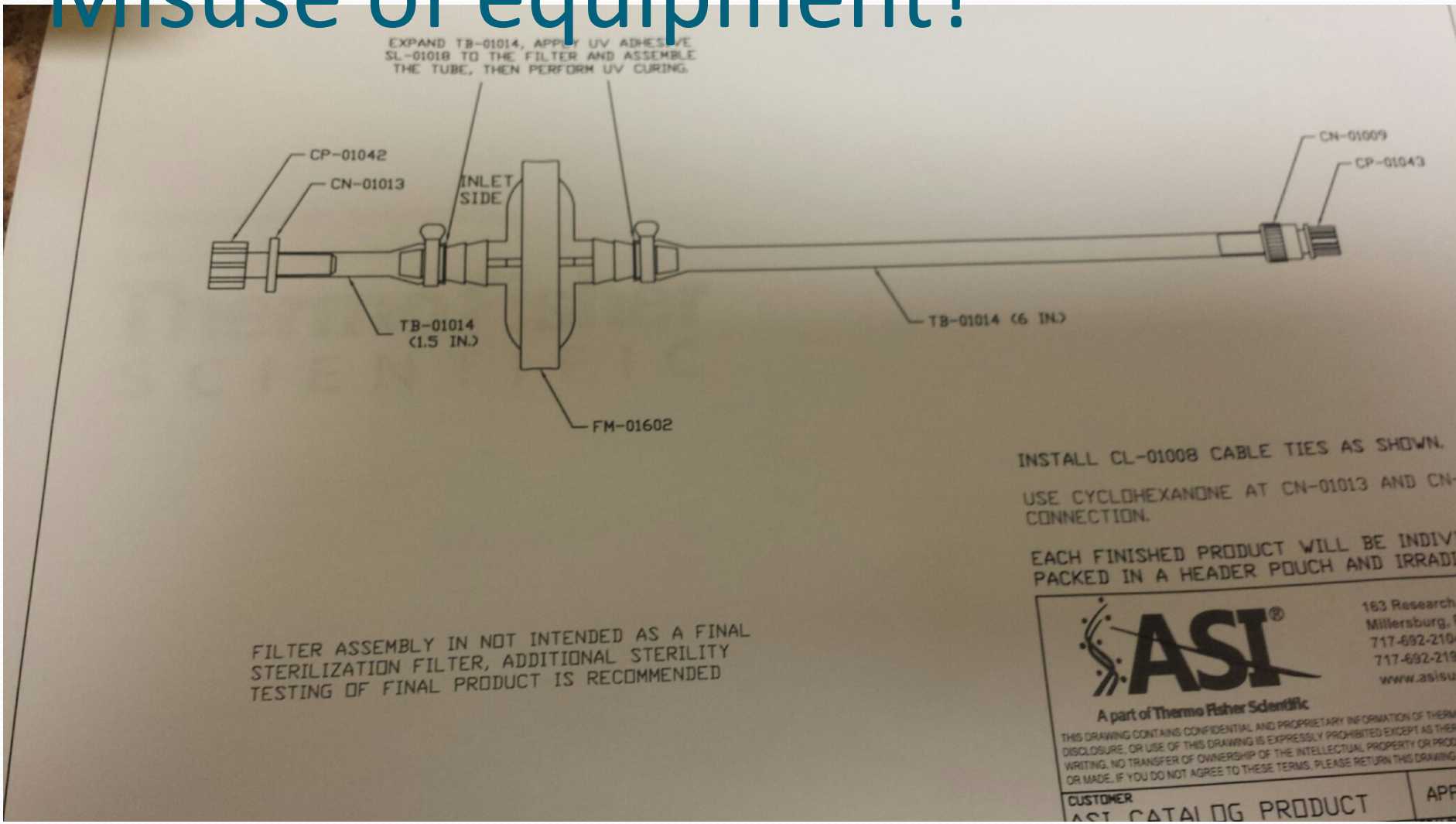
- 67 (19%) issued for noncompliance with sterile compounding quality assurance and process validation
  - 1751.7
  - 29 issued for noncompliance with process validation.
    - 1751.7(b)
  - 13 issued for noncompliance with a written quality assurance plan.
    - 1751.7(a)

Top Correction and Violations

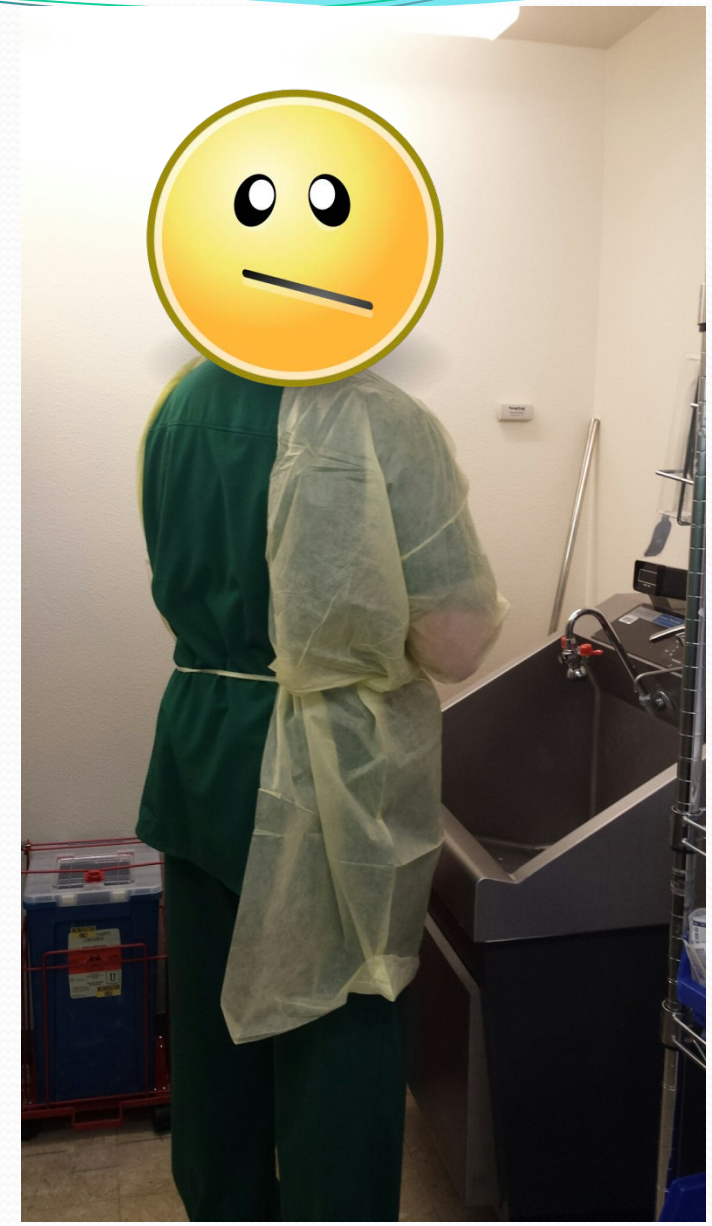
- 56 (16%) issued for noncompliance with records of compounded products
  - 1735.3
  - 39 (11%) issued for noncompliance with master formula and compounding log.
    - 1735.3(a)

Pictures…….

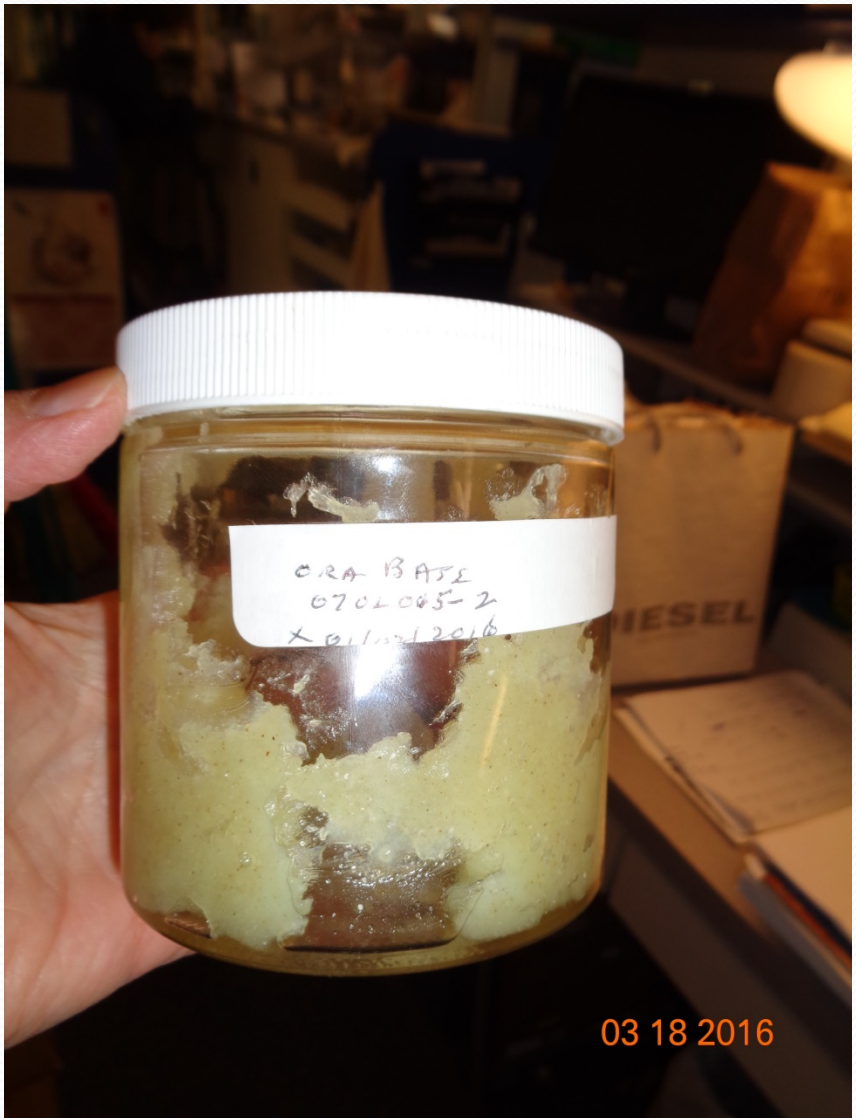
Misuse of equipment?



Proper Garbing?



Expired?


03 18 2016


The Day Drug Co.
YOUR Rexall STORE
POWELL AT SUTTER
SAN FRANCISCO
No.
Dr.
camphor water
KEEP ALL MEDICINES OUT OF THE REACH OF CHILDREN
PHONE 421-6566
SAM CHING, Pharmacist-Manager

Unlicensed staff?

Received recalled notices

- 7/1/16 to 4/7/17
  - 8 NRP
  - 2 PHY
  - 1 HSP

Issued Cease and Deists

- 7/1/16 to 4/7/17:
  - 1 PHY

- Questions

Attachment 7

16 CCR § 1735.6

§ 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 compounding of 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.
(e) Hazardous drug compounding shall be completed in an externally vented physically separate room with the following requirements:
(1) Minimum of 30 air changes per hour except that 12 air changes per hour are acceptable for segregated compounding areas with a BSC or CACI when products are assigned a BUD of 12 hrs or less or when non sterile products are compounded; and
(2) Maintained at a negative pressure of 0.01 to 0.03 inches of water column relative to all adjacent spaces (rooms, above ceiling, and corridors); and
(3) Each PEC in the room shall also be externally vented; and
(4) All surfaces within the room shall be smooth, seamless, impervious, and non-shedding.
(f) Where compliance with the January 1, 2017 amendments to Article 4.5 or Article 7, requires physical construction or alteration to a facility or physical environment, the board or its designee may grant a waiver of such compliance for a period of time to permit such physical change(s). Application for any waiver shall be made by the licensee in writing, and the request shall identify the provision(s) requiring physical construction or alteration, and the timeline for any such change(s). The board or its designee may grant the waiver when, in its discretion, good cause is demonstrated for such waiver.

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

16 CCR § 1751.4

§ 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 shall be done using a germicidal detergent and sterile water. The use of a sporicidal agent is required to be used at least monthly.
(1) All ISO Class 5 surfaces, work table surfaces, carts, counters, and the cleanroom floor shall be cleaned at least daily. After each cleaning, disinfection using a suitable sterile agent shall occur on all ISO Class 5 surfaces, work table surfaces, carts, and counters.
(2) Walls, ceilings, storage shelving, tables, stools, and all other items in the ISO Class 7 or ISO Class 8 environment shall be cleaned at least monthly.
(3) Cleaning shall also occur after any unanticipated event that could increase the risk of contamination.
(4) All cleaning materials, such as wipers, sponges, and mops, shall be non-shedding and dedicated to use in the cleanroom, or ante-area, and segregated sterile compounding areas and shall not be removed from these areas except for disposal.
(e) Disinfection, using a suitable sterile agent, shall also occur on all surfaces in the ISO Class 5 PEC frequently, including:
(1) At the beginning of each shift;
(2) At least every 30 minutes when compounding involving human staff is occurring or before each lot;
(3) After each spill; and
(4) When surface contamination is known or suspected.
(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-003-2006-13, Revised May 20, 2015), which is hereby incorporated by reference. Certification records must be retained for at least 3 years. Unidirectional compounding aseptic isolators or compounding aseptic containment isolators may be used outside of an ISO Class 7 cleanroom if the isolator is certified to meet 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 that do not meet the requirements as outlined in this subdivision or are not located within an ISO Class 7 cleanroom 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 505.7.1 of Title 24, Chapter 5, of the California Code of Regulations, requiring a negative pressure PEC. Additionally, each PEC used to compound hazardous agents shall be externally vented. 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-003-2006-13, Revised May 20, 2015), which is hereby incorporated by reference. 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.
(1) During the hazardous drug compounding that is performed in a compounding aseptic containment isolator, full hand hygiene and garbing must occur. Garbing shall include hair cover, facemask, beard cover (if applicable), polypropylene or low shedding gown that closes in the back, shoe covers, and two pairs of sterile ASTM D6978-05 standard gloves.
(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) Compounding aseptic isolator and compounding aseptic containment isolator used in the compounding of sterile drug preparations shall use non-turbulent unidirectional air flow patterns. A smoke patterned test shall be used to determine air flow patterns.
(j) Viable surface sampling shall be done at least every six months for all sterile-to-sterile compounding and quarterly for all non-sterile-to-sterile compounding. Viable air sampling shall be done by volumetric air sampling procedures which test a sufficient volume of air (400 to 1,000 liters) at each location and shall be done at least once every six months. Viable surface and viable 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. Viable 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 pursuant to its policies and procedures.

Remediation shall include, at minimum, an immediate investigation of cleaning and compounding operations and facility management.
(k) The sterile compounding area in the pharmacy shall have a comfortable and well-lighted working environment, which includes a room temperature of 20-24 degrees Celsius (68-75 degrees Fahrenheit) or cooler to maintain comfortable conditions for compounding personnel when attired in the required compounding garb.
(*l*) A licensee may request a waiver of these provisions as provided in section 1735.6(f).

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.

California State Board of Pharmacy
1625 N. Market Blvd, N219, Sacramento, CA 95834
Phone: (916) 574-7900
Fax: (916) 574-8618
www.pharmacy.ca.gov

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

Guidance on Applying for Compliance Delays During Construction In Pharmacies that Compound

Title 16 of the California Code of Regulations (CCR) section 1735.6 (f) states where compliance with California's compounding regulations requires physical construction or alteration to a facility or physical environment, the board may grant a waiver of such compliance for a period of time to permit the required physical changes. See also related provisions in CCR section 1751.4.

Application for any waiver must be made in writing, identify the provisions requiring physical construction or alteration, and provide a timeline for any such changes. The board may grant the waiver for a specified period when, in its discretion, good cause is demonstrated for such waiver.

For hospitals, please see Guidance on Applying for Compliance Delays During Construction in Hospital Pharmacies that Compound, to request an exemption.

Please submit your request via email to: Compounding.waivers@dca.ca.gov

Or mail to: Compounding Construction Waiver Request
CA State Board of Pharmacy
1625 N Market Boulevard, Suite N-219
Sacramento, CA 95834

Please retain a copy of your submitted request and make available for review at the licensed location.

Below is an example of the requested information in a format that you may submit to the board to request a waiver. It is in a fillable PDF format that you can complete online, printout, have signed and then return to the board along with any attachments. This document and form are available at www.pharmacy.ca.gov.

Pharmacy Name:

License Number: PHY/PHE

Please provide sterile compounding licenses associated with the above license: LSC/LSE

Name of the Individual Submitting this Request:

Title:

Email:

Phone Number:

The provisions of the regulation for which a compliance delay for construction is needed:
(Note: CA Code of Regulations section 1735.6(f) requires the identification of code sections requiring physical construction, alteration or improvement that are the reason for the waiver request)

☐ 1735.6, list subsections

☐ 1751.4 list subsections

☐ Please list if other sections

A description of the physical changes that must be made for compliance *(Attach additional page if necessary)*:

Please provide the timeframe for construction to completion:

Have building plans been developed? Yes ☐ No ☐

Has a building permit been secured? If yes, please provide number:

Please provide a written description of how the pharmacy will perform compounding while the compliance delay is in effect.

Reviewed by:

Pharmacy Pharmacist-in-Charge _____

Please Print

Signature: _____Date:_____

Please do not send architectural drawings or structural plans as they will not be reviewed.

California State Board of Pharmacy
1625 N. Market Blvd, N219, Sacramento, CA 95834
Phone: (916) 574-7900
Fax: (916) 574-8618
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BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

Guidance on Applying for Compliance Delays During Construction In Hospital Pharmacies that Compound

Title 16 of the California Code of Regulations (CCR) section 1735.6 (f) states where compliance with California's compounding regulations requires physical construction or alteration to a facility or physical environment, the board may grant a waiver of such compliance for a period of time to permit the required physical changes. See also related provisions in CCR section 1751.4.

Application for any waiver must be made in writing, identify the provisions requiring physical construction or alteration, and provide a timeline for any such changes. The board may grant the waiver for a specified period when, in its discretion, good cause is demonstrated for such waiver.

For non-hospitals, please see Guidance on Applying for Compliance Delays During Construction in Pharmacies that Compound, to request an exemption.

Please submit your request via email to: Compounding.waivers@dca.ca.gov

Or mail to: Compounding Construction Waiver Request
CA State Board of Pharmacy
1625 N Market Boulevard, Suite N-219
Sacramento, CA 95834

Please retain a copy of your submitted request and make available for review at the licensed location.

Below is an example of the requested information in a format that you may submit to the board to request a waiver. It is in a fillable PDF format that you can complete online, printout, have signed and then return to the board along with any attachments. This form is available at www.pharmacy.ca.gov.

Hospital Pharmacy Name:

License Number: HSP/HPE

Provide all sterile compounding license numbers associated with the above license that require modification as part of this request:
LSC LSC LSC LSC LSC LSC

Name of the Individual Submitting this Request:

Title:

Email:

Phone Number:

OSHPD Project Number for this modification (if applicable):

OSHPD Facility Identification (if applicable):

OSHPD Hospital Building Number (if applicable):

Please attach a copy of the Project Completion Timeline, including a specific timeline for construction for EACH compounding pharmacy location that needs modification and is included under this Project Number.

The provisions of the regulation for which a compliance delay for construction is needed:
(Note: CA Code of Regulations section 1735.6(f) requires the identification of code sections requiring physical construction, alteration or improvement that are the reason for the waiver request.)

- ☐ 1735.6, list subsections
- ☐ 1751.4 list subsections
- ☐ Please list if other sections

Please provide the timeframe for construction to completion:

A description of the physical changes that must be made for compliance *(Attach additional page if necessary)*:

Have building plans been developed? Yes ☐ No ☐

Has a building permit been secured? If yes, please provide number:

Please provide a written description of how the pharmacy will perform compounding while the compliance delay is in effect. Identify how compounding will take place after 1/1/17 until construction starts, during construction, and the transition into the newly remodeled location. (Please note if a new or temporary location is needed, a new permit may be required with the Board of Pharmacy and notification may be required to the California Department of Public Health. Additionally inspections are likely to be required before the use of any sterile compounding location begins operation. Please plan and communicate accordingly.)

Reviewed by:

Hospital Chief Executive Officer, Hospital Chief Operating Officer or Executive Director:

_____

Please Print Name and Title

Signature:_____Date:_____

Please do not send architectural drawings or structural plans as they will not be reviewed.

Attachment 8

Table I.1: The Number of State Pharmacy Regulatory Bodies Reporting That Their Office Has Primary Responsibility for the Oversight of Drug Compounding for Human Use

Type of drug compounder	Number of states (%)		
	Yes	No	No response
Drug compounding by pharmacies and pharmacists	50 (100)	0 (0)	0 (0)
Drug compounding by Food and Drug Administration registered outsourcing facilities	35 (70)	13 (26)	2 (4)
Drug compounding by physicians	7 (14)	41 (82)	2 (4)
Drug compounding by other nonpharmacist health care practitioners (e.g., nurse practitioners, physician assistants)	8 (16)	41 (82)	1 (2)

Source: GAO survey of state pharmacy regulatory bodies, survey question 2. | GAO-17-363SP

Note: GAO surveyed the state pharmacy regulatory bodies in the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands, and all but 4 completed the survey.

Attachment 9

Road Runner Summarized Statement for Enforcement Committee Meeting
Excerpt for January 24, 2017 Draft Board Meeting Minutes

Morgan McCloud, representing Road Runner Veterinary Compounding Pharmacy located in Phoenix, Arizona, requested the board exempt veterinary compounding from some of the requirements in the compounding regulations.

Mr. McCloud reported to the board a colleague Jeremy Schmidt addressed the January 4, 2017, Enforcement and Compounding Committee regarding the recent adoption of new BUD dating and testing for compounding medications and the need for the veterinary community to be exempted from California Code of Regulations (CCR) section 1735.2. Method suitability tests and container closure integrity tests normally associated with sterile products are now mandated for nonsterile products if BUD dating extension is to occur. Additionally, stability studies in the same paragraph can be interpreted differently. Using stability indicators, a common process used in manufacturing could add as much as $20,000 to the BUD analysis and would significantly raise costs to pet owners, of which most have no insurance dramatically decreasing pet patient care. Due to differences in the practice of veterinary medicine versus human medicine, the Enforcement and Compounding Committee agreed to add the topic to their agenda at the next committee meeting.

Mr. McCloud explained to the board the importance of the request for exemption and to ensure the board is aware of the impact of compounding medications within the veterinary community. He explained in the veterinary practice, it is expected for the veterinarian to have the appropriate medication for the pets. Due to the wide range of patients seen by veterinarians and unavailability of select drugs and strengths, the treatments often come from compounded office stock. Mr. McCloud explained the newly required testing could add as much as $30,000 annually per a medication leaving pets to go untreated due to the costs. Additionally, the requirement for the practitioner to explain why a compounded product over commercial product has been selected seems counterintuitive. Mr. McCloud continued that mandates requiring the office stock to indicate the number of patients the medication is to serve and quantities expected to administer in the clinic as well as the average volume dispensed for a 120-hour supply are illogical in the typical veterinary practice.

Mr. McCloud requested veterinary medications be exempted for these additional requirements because the medical needs for animals are met differently than those of humans. Due to the on-demand service nature of veterinary medicine, the unique nature of veterinary medicines and dosages, the unavailability of most commercial drugs to meet those needs, Road Runner Veterinary Compounding Pharmacy requests a consideration for exemption in veterinary practices or at least request the board place this item on the agenda for further discussion at the next meeting.

California Code of Regulations § 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 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 office administration; 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 120-hour supply for veterinary medical practices, solely to the prescriber's own veterinary 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 it is a reasonable quantity for office use 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 document 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 and essential 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 compendia 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 or date and time beyond which the compounded drug preparation should not be used, stored, transported or administered, and determined based on the professional judgment of the pharmacist performing or supervising the compounding.

(1) For non-sterile compounded drug preparation(s), the beyond use date shall not exceed any of the following:

(A) the shortest expiration date or beyond use date of any ingredient in the compounded drug preparation,

(B) the chemical stability of any one ingredient in the compounded drug preparation;

(C) the chemical stability of the combination of all ingredients in the compounded drug preparation,

(D) 180 days for non-aqueous formulations,

(E) 14 days for water-containing oral formulations, and

(F) 30 days for water-containing topical/dermal and mucosal liquid and semisolid formulations.

(2) For sterile compounded drug preparations, the beyond use date shall not exceed any of the following:

(A) The shortest expiration date or beyond use date of any ingredient in the sterile compounded drug product preparation,

(B) The chemical stability of any one ingredient in the sterile compounded drug preparation,

(C) The chemical stability of the combination of all ingredients in the sterile compounded drug preparation, and

(D) The beyond use date assigned for sterility in section 1751.8.

(3) Extension of a beyond use date is only allowable when supported by the following:

(A) Method Suitability Test,

(B) Container Closure Integrity Test, and

(C) Stability Studies

(4) In addition to the requirements of paragraph three (3), the drugs or compounded drug preparations tested and studied shall be identical in ingredients, specific and essential compounding steps, quality reviews, and packaging as the finished drug or compounded drug preparation.

(5) 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) 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 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) 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.

(2) such ingredients cannot be used for any sterile compounded drug preparation more than one (1) year after the data of receipt by the pharmacy

Attachment 10

Interim Policy on Compounding Using Bulk Drug Substances Under Section 503A of the Federal Food, Drug, and Cosmetic Act

Guidance for Industry

U.S. Department of Health and Human Services
Food and Drug Administration
Center for Drug Evaluation and Research (CDER)
Office of Compliance/OUDLC

January 2017
Compounding and Related Documents
Revision 1

Interim Policy on Compounding Using Bulk Drug Substances Under Section 503A of the Federal Food, Drug, and Cosmetic Act

Guidance for Industry

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U.S. Department of Health and Human Services
Food and Drug Administration
Center for Drug Evaluation and Research (CDER)
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Contains Nonbinding Recommendations

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Guidance for Industry[1]

Interim Policy on Compounding Using Bulk Drug Substances Under Section 503A of the Federal Food, Drug, and Cosmetic Act

This guidance represents the current thinking of the Food and Drug Administration (FDA or Agency) on this topic. It does not establish any rights for any person and is not binding on FDA or the public. You can use an alternative approach if it satisfies the requirements of the applicable statutes and regulations. To discuss an alternative approach, contact the FDA office responsible for this guidance as listed on the title page.

I. INTRODUCTION AND SCOPE

This guidance sets forth the Food and Drug Administration's (FDA or Agency) interim regulatory policy concerning compounding using bulk drug substances under section 503A of the Federal Food, Drug, and Cosmetic Act (FD&C Act or Act). Section 503A of the FD&C Act includes certain restrictions on the bulk drug substances that can be used in compounding and directs FDA to develop a list of bulk drug substances that can be used in compounding under that section. FDA is developing this list of bulk drug substances (the 503A bulks list), and this guidance describes FDA's interim regulatory policy for licensed pharmacists in State-licensed pharmacies and Federal facilities and for licensed physicians that compound human drug products using bulk drug substances while the list is being developed.[2,3]

In general, FDA's guidance documents do not establish legally enforceable responsibilities. Instead, guidances describe the Agency's current thinking on a topic and should be viewed only as recommendations, unless specific regulatory or statutory requirements are cited. The use of the word *should* in Agency guidances means that something is suggested or recommended, but not required.

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[1] This guidance has been prepared by multiple offices in the Center for Drug Evaluation and Research (CDER), in consultation with the Office of Regulatory Affairs at the Food and Drug Administration.

[2] This guidance does not apply to drugs compounded from bulk drug substances for use in animals. For proposed policies pertaining to compounding drug products from bulk drug substances for use in animals, see FDA's draft guidance, *Compounding Animal Drugs from Bulk Drug Substances*.

> All FDA guidances are available on the FDA guidance web page. FDA updates guidances regularly. To make sure you have the most recent version of a guidance, always consult the guidance web page at http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm.

[3] FDA is developing a separate list of bulk drug substances that can be used in compounding under section 503B of the FD&C Act. Because section 503B contains different criteria for that list and provides for a different process for its development, the section 503B bulks list is covered under a separate guidance (see guidance for industry, *Interim Policy on Compounding Using Bulk Drug Substances Under Section 503B of the Federal Food, Drug, and Cosmetic Act*).

II. BACKGROUND

A. Compounding From Bulk Drug Substances Under Section 503A of the Act

Section 503A of the FD&C Act describes the conditions that must be satisfied for human drug products compounded by a licensed pharmacist in a State-licensed pharmacy or Federal facility, or by a licensed physician, to be exempt from the following three sections of the FD&C Act: section 505 (concerning the approval of drugs under new drug applications or abbreviated new drug applications); section 502(f)(1) (concerning the labeling of drugs with adequate directions for use); and section 501(a)(2)(B) (concerning current good manufacturing practice requirements).

One of the conditions that must be met for a compounded drug product to qualify for these exemptions is that a licensed pharmacist, or licensed physician compounds the drug product using bulk drug substances that:

1. Comply with the standards of an applicable United States Pharmacopeia (USP) or National Formulary (NF) monograph, if a monograph exists, and the USP chapter on pharmacy compounding;
2. If such a monograph does not exist, are drug substances that are components of drugs approved by the Secretary; or
3. If such a monograph does not exist and the drug substance is not a component of a drug approved by the Secretary, appears on a list developed by the Secretary through regulations issued by the Secretary under subsection (c) of section 503A.[4]

A bulk drug substance is defined as meaning "the same as active pharmaceutical ingredient as defined in 21 CFR 207.1(b)." See 21 CFR 207.3. Active pharmaceutical ingredient is defined as "any substance that is intended for incorporation into a finished drug product and is intended to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body," but the term "does not include intermediates used in the synthesis of the substance" (see section 503A(b)(1)(A) and 21 CFR 207.3).[5,6] FDA has interpreted "an applicable USP or NF

[4] See Section 503A(b)(1)(A)(i) of the FD&C Act.

[5] Section 503A references the definition of bulk drug substances in FDA's drug establishment registration and listing regulations, which was codified at 21 CFR 207.3(a)(4) when section 503A was enacted. On August 31, 2016, FDA published a final rule in the Federal Register to update its registration and listing regulations in Part 207, which made minor changes to the definition of bulk drug substance and moved the definition to 21 CFR 207.3 *See* 81 FR 169 (August 31, 2016). Under the previous definition, bulk drug substance was defined to mean "any substance that is represented for use in a drug and that, when used in the manufacturing, processing, or packaging of a drug, becomes an active ingredient or a finished dosage form of the drug, but the term does not include intermediates used in the synthesis of such substances."

[6] Inactive ingredients are not subject to section 503A(b)(1)(A)(i) or the policies described in this guidance because they are not included within the definition of a bulk drug substance. *See* 21 CFR 207.3. Pursuant to section 503A(b)(1)(B), inactive ingredients used in compounding must comply with the standards of an applicable United States Pharmacopeia or National Formulary monograph, if a monograph exists, and the USP chapter on pharmacy compounding.

monograph" to mean an official USP or NF **drug substance** monograph. Accordingly, FDA does not consider USP monographs for dietary supplements to be "applicable" USP or NF monographs within the meaning of section 503A(b)(1)(A)(i)(I).

Under section 503A(c)(1), before developing this list through regulation, FDA must convene and consult an advisory committee on compounding unless FDA determines that the issuance of such regulation before consultation with the advisory committee is necessary to protect the public health. FDA must also consult with USP when promulgating the regulations.[7] The criteria for determining which bulk drug substances should appear on the section 503A bulks list "shall include historical use, reports in peer reviewed medical literature, or other criteria the Secretary may identify."[8]

Bulk drug substances used in compounding under section 503A must also meet certain other requirements, including: (1) the bulk drug substance must be manufactured by an establishment registered under section 510 of the FD&C Act and (2) the bulk drug substance must be accompanied by a valid certificate of analysis (COA).[9]

In July 2014, FDA issued a guidance, *Pharmacy Compounding of Human Drug Products Under Section 503A of the Federal Food, Drug, and Cosmetic Act*, that states:

> Until a bulk drug substances list is published in the *Federal Register* as a final rule, human drug products should be compounded using only bulk drug substances that are components of drugs approved under section 505 of the FD&C Act, or are the subject of USP or NF monographs.[10]

FDA has received comments that this policy could be causing unnecessary and inappropriate disruptions in patient care because there are patients receiving drugs compounded with bulk drug substances that are not components of FDA-approved drugs, or the subject of an applicable USP or NF monograph, but that may ultimately be included on the 503A bulks list, and those patients' care should not be disrupted while the list is under development. After considering this issue, FDA has decided to use this guidance to describe its interim policy concerning compounding with bulk drug substances while the 503A bulks list is being developed. FDA has revised the July 2014 guidance to state:

> FDA's interim policy concerning bulk drug substances that are not components of drugs approved under section 505 of the FD&C Act or that are not the subject of applicable USP or NF monographs can be found in the guidance, *Interim Policy on*

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[7] See section 503A(c)(2) of the FD&C Act.

[8] See section 503A(c)(2) of the FD&C Act.

[9] See section 503A(b)(1)(A) of the FD&C Act.

[10] See page 5 of the guidance, *Pharmacy Compounding of Human Drug Products Under Section 503A of the Federal Food, Drug, and Cosmetic Act*.

Compounding Using Bulk Drug Substances Under Section 503A of the Federal Food, Drug and Cosmetic Act.

FDA seeks to avoid unnecessary disruption to patient treatment while the Agency considers the bulk drug substances that were nominated with sufficient support to permit FDA to evaluate them and promulgates the regulations required under section 503A. Therefore, as described further below, FDA is issuing this interim guidance stating that it does not intend to take regulatory action for compounding drug products under section 503A using a bulk drug substance when an applicable USP or NF monograph for the substance does not exist and the substance is not a component of an FDA-approved product if, among other conditions, FDA has determined that the nomination for the bulk drug substance included adequate information for FDA to evaluate the substance and at this time, the substance does not appear to present significant safety risks.

B. Efforts to Develop the List of Bulk Drug Substances under Section 503A

1. Section 503A Bulks List — Early History

Section 503A was enacted in 1997 as part of the Food and Drug Administration Modernization Act. In the *Federal Register* of April 7, 1998 (63 FR 17011), FDA invited all interested persons to nominate bulk drug substances for inclusion on the list of bulk drug substances that can be used in compounding under section 503A and received nominations for 41 different drug substances. In November 1998, FDA published a guidance for industry, *Enforcement Policy During Implementation of Section 503A of the Federal Food, Drug, and Cosmetic Act.* In this guidance, FDA announced that it would not normally take regulatory action relating to a drug product that had been compounded with a bulk drug substance that had been nominated for inclusion on the bulk drug substances list on or before November 21, 1999, while the substance was being evaluated, as long as the compounding complied with the other effective requirements in section 503A and did not appear to present a significant safety risk.[11]

In January 1999, after evaluating the nominated drug substances and consulting with the Pharmacy Compounding Advisory Committee (PCAC) as required by section 503A, FDA published a proposed rule listing 20 drug substances on the section 503A bulks list (64 FR 996, January 7, 1999). The preamble to the proposed rule indicated that 10 of the 41 nominated substances were the subject of a USP or NF monograph, or components of FDA approved drugs and did not need to be considered for inclusion on the list.[12] The proposed rule also described 10 nominated substances that were still under consideration for the bulk drug substances list and stated that one of the substances was withdrawn by its nominator at the first meeting of the PCAC. The PCAC reconvened in May 1999 to discuss bulk drug substances included in the proposed rule, in addition to other bulk drug substances (64 FR 19791; April 22, 1999).

[11] The 1998 guidance was withdrawn in the *Federal Register* notice announcing the availability of the draft guidance *Pharmacy Compounding of Human Drug Products Under Section 503A of the Federal Food, Drug, and Cosmetic Act*. See 78 FR 72901 (Dec. 4, 2013). The final guidance was published in July 2014.

[12] See 64 FR 996, at 997 (January 7, 1999).

However, after a 2002 U.S. Supreme Court decision holding that certain provisions of section 503A were unconstitutional,[13] FDA suspended its efforts to develop the bulk drugs list under section 503A.

Because of the amount of time that had passed between the publication of the proposed rule and the enactment of the 2013 Drug Quality and Security Act, which removed the provisions of the FD&C Act that the U.S. Supreme Court held to be unconstitutional in 2002, FDA felt it was necessary to begin again to develop the section 503A bulk drug substance list. In the December 4, 2013, *Federal Register* (78 FR 72841), FDA published a notice withdrawing the 1999 proposed rule and inviting all interested persons to nominate bulk drug substances for inclusion on a list of bulk drug substances that can be used for compounding under section 503A of the FD&C Act.

2. Current Nominations for the 503A Bulks List

In response to the December 2013, *Federal Register* notice, over 2,000 substances were nominated for the 503A bulks list. However, many of the substances nominated for the 503A list were for substances that can be compounded without being on the list because they are the subject of an applicable USP or NF monograph or are a component of an FDA-approved drug. In addition, many of the nominations were not for substances used in compounding as active ingredients, or did not include sufficient information for FDA to evaluate the nominated substances for inclusion on the list. To improve the efficiency of the process for developing the 503A bulks list, FDA reopened the nomination process in July 2014 (79 FR 37742) and provided more detailed information on what it needs to evaluate nominations for the 503A bulks list. FDA stated that bulk drug substances that were previously nominated would not be considered further unless they were re-nominated with adequate support to permit a meaningful evaluation. Substances that were already eligible for use in compounding or that were not adequately supported would not be evaluated for placement on the 503A bulks list.

In response to this request for nominations, approximately 740 unique substances were nominated. Of the nominated substances:

- Approximately 315 substances are already eligible for use in compounding under section 503A.

  These are the subject of an applicable USP or NF monograph or components of an FDA-approved drug product, which can be used in compounding pursuant to sections 503A(b)(1)(A)(i)(I) and (II) and, therefore, can be compounded without being included on the 503A bulks list. To determine if a bulk drug substance is the subject of an applicable USP or NF monograph, see the *USP-NF* available at www.USPNF.com. To determine if a bulk drug substance is a component of an FDA approved drug, see the FDA's *Orange Book:*

[13] For additional legal history of section 503A, see the guidance *Pharmacy Compounding of Human Drug Products Under Section 503A of the Federal Food, Drug, and Cosmetic Act*.

Approved Drug Products with Therapeutic Equivalence Evaluations, available at http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm.

- At least one[14] of the nominated substances is not a bulk drug substance.

This is a finished drug product that was nominated by its brand name. Finished drug products are not eligible for the 503A bulks list because they do not meet the definition of a bulk drug substance in 21 CFR 207.3.

- At least one of the substances is considered a biological product subject to approval in a biologics license application (BLA) under section 351 of the Public Health Service (PHS) Act when used for the indication proposed in the nomination.

This substance is not eligible for the 503A bulks list because biological products subject to approval in a BLA under section 351 of the PHS Act are not eligible for the exemptions in section 503A of the FD&C Act.[15] No biological products subject to approval in a BLA will be considered for the 503A bulks list.

- At least four of the nominated substances appear on the list published by FDA of substances that have been withdrawn or removed from the market because such drug products or components of such drug products have been found to be unsafe or not effective (withdrawn or removed list).[16]

Such substances cannot be used in compounding under section 503A of the FD&C Act and, therefore, are not eligible for inclusion on the 503A bulks list.

- One of the nominated substances has no currently accepted medical use and is included on Schedule I of the Controlled Substances Act (CSA) (21 U.S.C. § 812(c)).[17]

The CSA does not allow possession or distribution of Schedule I substances (21 USC §§ 841(a)(1) and 829), except for research purposes (21 U.S.C. § 823(f)), and these substances will not be considered for the 503A bulk drug substances list at this time. Those desiring to do research on a Schedule I substance can apply to do so under an investigational new drug application (IND).

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[14] The over-the-counter finished drug product Maalox was nominated. Maalox is not a bulk drug substance.

[15] The nominated substance is sodium hexachloroplatinate (IV) hexahydrate. See the revised draft guidance, *Mixing, Diluting, or Repackaging Biological Products Outside the Scope of an Approved Biologics License Application* for FDA's proposed policies regarding State-licensed pharmacies, Federal facilities, and outsourcing facilities that mix, dilute, or repackage biological products outside the scope of an approved BLA.

[16] See Section 503A(b)(1)(C) of the FD&C Act. See also 21 CFR 216.24. The four substances are: chloroform reagent, cobalt chloride hexahydrate, cobalt gluconate, and phenacetin.

[17] An extract of cannabidiol (CBD) and tetrahydrocannabinol (THC) derived from marijuana (marihuana) was nominated. Marijuana (marihuana) is a Schedule I substance.

- Of the substances that are not components of an approved drug or the subject of an applicable USP or NF monograph and that are not biological products subject to licensure in a BLA or included on Schedule I of the CSA, and do not appear on the withdrawn or removed list, approximately 350 substances were nominated without sufficient supporting evidence for FDA to evaluate them.

- The remaining substances may be eligible for inclusion on the 503A list and were nominated with sufficient supporting information for FDA to evaluate them. However, FDA has identified significant safety risks relating to the use of some of these bulk drug substances in compounded drug products.

FDA's website identifies the following categories of substances nominated for the 503A bulks list:[18]

503A Category 1 – Substances Nominated for the Bulks List Currently Under Evaluation: These substances may be eligible for inclusion on the 503A bulks list, were nominated with sufficient supporting information for FDA to evaluate them, and do not appear on any other list.

503A Category 2 – Substances Nominated for the Bulks List That Raise Significant Safety Risks: These substances were nominated with sufficient supporting information to permit FDA to evaluate them and they may be eligible for inclusion on the 503A bulks list. However, FDA has identified significant safety risks relating to the use of these substances in compounding pending further evaluation, and therefore does not intend to adopt the policy described for the substances in Category 1. If FDA adds a substance to Category 2, it will publish a public communication (e.g., a safety alert) describing the safety risks and will post the communication on FDA's human drug compounding website,[19] advising that the substance has been added to Category 2 and is no longer eligible for the policies that apply to substances in Category 1.

503A Category 3 – Substances Nominated for the Bulks List Without Adequate Support: These substances may be eligible for inclusion on the 503A bulks list, but were

[18] http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/UCM467373.pdf. As discussed in the July 2014 Federal Register notice requesting nominations for the 503A bulks list (79 FR 37742), nominators were to confirm that all substances nominated for the list are active ingredients that meet the definition of a "bulk drug substance." Inclusion of a substance in any of these categories does not reflect a determination by FDA that the substance is a bulk drug substance. Whether a substance is a bulk drug substance subject to the conditions in section 503A(b)(1)(A) depends on whether it meets the definition of a bulk drug substance in 21 CFR 207.3. If the substance is used in a compounded drug as an inactive ingredient, then it does not meet the definition of a bulk drug substance in 21 CFR 207.3, is not subject to the conditions in section 503A(b)(1)(A), and need not appear on the 503A bulks list to be eligible for use in compounding. Instead, when used as an inactive ingredient, the substance is subject to the conditions in section 503A(b)(1)(B), which applies to ingredients other than bulk drug substances used in compounded drugs.

[19] http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/default.htm. FDA also encourages compounding facilities to subscribe to FDA's list serve to receive updates at: http://service.govdelivery.com/service/subscribe.html?code=USFDA_429.

nominated with insufficient supporting information for FDA to evaluate them. These substances can be re-nominated with sufficient supporting information through a docket that FDA has established, as discussed below in section III.B.

3. Process for Developing the 503A List

FDA is currently evaluating the substances that were nominated for the 503A bulks list with sufficient information to permit evaluation. FDA is considering a number of factors in prioritizing the order in which it reviews the nominated bulk drug substances, including but not limited to the following:

- Safety concerns about use of the bulk drug substance in compounding
- Whether the bulk drug substance was nominated by multiple parties or identified as necessary by medical professional organizations
- The efficiency with which the evaluation can be completed, based on ease of acquiring the necessary information to conduct the review, available resources, and other logistical issues

FDA may also group some nominated drug substances to facilitate efficient review and discussion. These include drugs that raise similar issues (e.g., vitamins or botanicals) or have been nominated for the treatment of the same condition (e.g., warts).

In conducting its evaluations, FDA reviews the information provided in support of the nomination and other available information to assess each bulk drug substance according to the following four criteria discussed at the PCAC meeting on February 23, 2015:

- The physical and chemical characterization of the substance
- Any safety issues raised by the use of the substance in compounded drug products
- Historical use of the substance in compounded drug products, including information about the medical condition(s) the substance has been used to treat and any references in peer-reviewed medical literature
- The available evidence of effectiveness or lack of effectiveness of a drug product compounded with the substance, if any such evidence exists

In evaluating candidates for the 503A bulks list under these criteria, FDA is using a balancing test. No single one of these criteria is dispositive; rather, FDA is considering each criterion in the context of the others and balancing them, on a substance-by-substance basis, to evaluate whether a particular substance is appropriate for inclusion on the list.

Once the evaluation of a substance is complete, FDA will present the results of its review to the PCAC to obtain its advice on whether to include the substance on the list.[20]

[20] See Section 503A(c)(1) of the FD&C Act.

Section 503A requires that FDA create the 503A bulks list by regulation in consultation with the USP. To this end, FDA has been periodically meeting with USP and discussing the list. FDA will publish a notice of proposed rulemaking (NPRM) that identifies substances FDA proposes for placement on the 503A bulks list and the substances FDA has evaluated but is not proposing to include on the 503A bulks list. After publication of the NPRM, the public will have an opportunity to comment on the proposed rule. After considering the comments submitted to the docket, FDA will publish a final rule that establishes the 503A bulks list and identifies the substances that were considered and will not be placed on the list. FDA does not intend to evaluate all of the sufficiently supported nominations before publishing the first NPRM. Instead, after FDA has made a decision on whether to propose a group of substances (e.g., 10 substances) it intends to publish an NPRM with respect to that group of substances and continue to prepare the list on a rolling basis.

A final rule will list the substances that FDA has determined can be used in compounding under section 503A and those substances that have been evaluated and not placed on the 503A bulks list, if any.

After a final rule is published, drug products compounded using the substances on the 503A bulks list will be eligible for the section 503A exemptions provided the drug product is compounded in compliance with the other conditions of section 503A. Those substances that have been evaluated and not placed on the 503A bulks list will not qualify for the policies described for the substances in Category 1.

III. POLICY[21]

A. Compounding from Bulk Drug Substances under Section 503A

Under section 503A of the FD&C Act, a bulk drug substance that is not the subject of an applicable USP or NF monograph or is not a component of an FDA-approved drug cannot be used in compounding unless it appears on a list promulgated as a regulation pursuant to section 503A(b)(1)(A)(i)(III) of the FD&C Act. This list will be codified at 21 CFR part 216 subpart E.

However, until a substance has been evaluated and is identified in a final rule as being included or not included on the 503A bulks list, FDA does not intend to take action against a State-licensed pharmacy, Federal facility, or licensed physician compounding a drug product using a bulk drug substance that is not a component of an FDA-approved drug product and that is not the subject of an applicable USP or NF monograph, provided that the following conditions are met:

1. The bulk drug substance appears in 503A Category 1 on FDA's website at http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/UCM467373.pdf. A Category 1 substance may be eligible for inclusion on the 503A bulks list, was nominated with sufficient supporting information for FDA to

[21] See the Appendix for a chart summarizing FDA's interim policy.

evaluate it and has not been identified by FDA as a substance that presents a significant safety risk in compounding prior to the publication of a final rule.

2. The original manufacturer and all subsequent manufacturers of the bulk drug substance are establishments that are registered under section 510 (including foreign establishments that are registered under section 510(i)) of the FD&C Act);

3. The bulk drug substance is accompanied by a valid COA; and

4. The drug product compounded using the bulk drug substance is compounded in compliance with all other conditions of section 503A of the FD&C Act.

Original manufacturer means the entity that originally produced the bulk drug substance and not a subsequent packer, repacker, labeler, or distributor.

This policy does not apply to a licensed pharmacist in a State-licensed pharmacy or Federal facility, or a licensed physician, that compounds a drug using a bulk drug substance that does not meet each of the above conditions, and the bulk drug substance is not the subject of an applicable USP or NF monograph or a component of an FDA-approved drug.

B. Substances Not Nominated or Nominated Without Adequate Support

As stated above, one of the categories of bulk drug substances FDA has identified on its website is substances nominated for the 503A bulks list that may be eligible for inclusion on the list, but that FDA is unable to evaluate for inclusion on the list at this time because the substances were nominated with insufficient supporting evidence for FDA to evaluate them (503A Category 3). In the *Federal Register* of October 27, 2015, FDA established a docket (October docket) where these substances can be re-nominated with sufficient supporting information or where nominations for substances that were not previously nominated can be submitted.

After a substance is nominated to the October docket,[22] FDA will determine whether the nomination is supported with sufficient information to allow FDA to evaluate it. After FDA makes that determination, the nominated substance will be placed in one of the three categories described in section II.B.2 above, and the categorization will be published on the FDA website. Once the category of a substance is published, FDA intends to apply the policy described in Section III.A of this guidance to that substance. FDA generally expects to categorize bulk drug substances nominated to the October docket and to publish updated categories on its website on the first business day of each month. Please note that until substances nominated for the October docket have been categorized, the policy does ***not*** apply to those substances.

C. Comments about Nominated Bulk Drug Substances

[22] This includes re-nominations of substances with sufficient supporting information.

If you feel that a substance that you nominated does not appear on the appropriate list or category as described in this guidance you can submit your comment to docket number FDA-2015-N-3534. If you have new information on a previously nominated substance that was placed in Category 3, the substance can be re-nominated with the additional information.

A nominator may also submit a comment to the docket requesting withdrawal of any of its nominations. If the party nominating the substance was the sole nominator, FDA will update the categories described in this guidance to reflect the withdrawn nomination.[23] FDA intends to provide notice to the public before removing any nominated substances from Category 1 or Category 2.

Withdrawal of a nomination upon the nominator's request and the resulting updates to the categories described in this guidance, do not reflect a determination by FDA regarding the validity of the nomination or of any reasons given by the nominator for requesting withdrawal. In addition, FDA may continue to evaluate a substance at its discretion even if the nominator submits a comment requesting withdrawal of the nomination.

[23] If multiple parties nominated the same substance, each party that nominated the substance must withdraw its nomination for the nominated substance to be considered withdrawn and for the categories to be updated to reflect that withdrawal.

APPENDIX: SUMMARY OF POLICY

The following table summarizes the interim policy for bulk drug substances set forth in this guidance:

Category	FDA Policy
The bulk drug substance appears in 503A Category 1 on FDA's website at http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/UCM467373.pdf. Such substances may be eligible for inclusion on the 503A bulks list, were nominated with sufficient supporting information for FDA to evaluate them, and do not appear to present a significant safety risk.	FDA does not intend to take action for compounding a drug product from a bulk drug substance in Category 1 that does not meet the conditions of section 503A(b)(1)(A)(i), provided that the bulk drug substance was manufactured by an establishment registered with FDA under section 510 of the FD&C Act and is accompanied by a valid COA from the entity that originally produced the bulk drug substance and provided that the drug compounded from the bulk drug substance is compounded in compliance with the other conditions of section 503A.
The bulk drug substance is a component of an FDA-approved drug and/or the subject of an applicable USP or NF monograph.	The bulk drug substance can be used in compounding under section 503A of the FD&C Act, provided it complies with the standards of the monograph (if one exists) and is compounded in compliance with the other conditions of section 503A.
The bulk drug substance appears on the withdrawn or removed list.	The bulk drug substance cannot be used in compounding under section 503A of the FD&C Act. A drug compounded using the bulk drug substance is subject to regulatory action.
The bulk drug substance appears in 503A Category 2 on FDA's website at http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/UCM467373.pdf. The substance has been identified by FDA as presenting a significant safety risk pending further evaluation.	The bulk drug substance cannot be used in compounding under section 503A of the FD&C Act unless and until FDA publishes a final rule authorizing its use under section 503A.
The bulk drug substance is a biological product subject to approval in a BLA.	The bulk drug substance is not eligible for the 503A bulks list. FDA has issued a separate draft guidance document describing the Agency's proposed policies concerning mixing, diluting, and repackaging biological products subject to approval in a BLA.[24]
The bulk drug substance appears in 503A Category 3 on FDA's website at http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/UCM467373.pdf. The substance may be eligible for inclusion on the 503A bulks list, but was nominated with insufficient supporting information for FDA to evaluate it.	The bulk drug substance cannot be used in compounding under section 503A of the FD&C Act. See section III.B of this guidance for information about re-nominating substances that were previously nominated with insufficient supporting information.

[24] See FDA's revised draft guidance, *Mixing, Diluting, and Repackaging Biological Products Subject to Approval in a Biologics License Application*.

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Bulk Drug Substances Nominated for Use in Compounding Under Section 503A of the Federal Food, Drug, and Cosmetic Act

503A Category 1 – Bulk Drug Substances Under Evaluation

- 7 Keto Dehydroepiandrosterone
- Acetyl L Carnitine/Acetyl-L-carnitine hydrochloride
- Acetyl-D-Glucosamine
- Alanyl-L-Glutamine
- Aloe Vera/ Aloe Vera 200:1 Freeze Dried
- Alpha Lipoic Acid
- Ammonium Tetrathiomolybdate
- Artemisia/Artemisinin
- Astragalus Extract 10:1
- Beta Glucan (1,3/1,4-D)
- Boswellia
- Brilliant Blue
- Bromelain
- Cantharidin
- Capsaicin palmitate
- Cesium Chloride
- Cetyl Myristoleate
- Choline Chloride
- Chondroitin Sulfate
- Chrysin
- Curcumin
- Deoxy-D-Glucose
- Dichloroacetate
- Diindolylmethane
- Dimercapto-1-propanesulfonic acid (DMPS)
- Diphenylcyclopropenone (DPCP)
- EGCg
- Ferric Subsulfate
-
- Glutaraldehyde
- Glutathione
- Glycoaminoglycans
- Glycolic Acid
- Glycyrrhizin
- Kojic Acid
- L-Citrulline
- Methylcobalamin
- Methylsulfonylmethane (MSM)
- Nettle leaf (Urtica dioica subsp. dioica leaf)
- Nicotinamide Adenine Dinucleotide (NAD)
- Nicotinamide Adenine Dinucleotide Disodium Reduced (NADH)
- Ornithine Hydrochloride
- Oxitriptan
- Phosphatidylserine
- Piracetam
- Pregnenolone
- Pyridoxal 5-Phosphate Monohydrate
- Pyruvic Acid
- Quercetin/Quercetin Dihydrate
- Quinacrine Hydrochloride (except for intrauterine administration)
- Resveratrol
- Ribose (D)
- Rubidium Chloride
- Silver Protein Mild
- Squaric Acid Dibutyl Ester (aka dibutyl squarate)
- Tea tree oil (Melaleuca alternifolia leaf oil)
- Thymol Iodide
- Tranilast
- Trichloroacetic Acid
- Ubiquinol 30% Powder
- Vanadium
- Vasoactive Intestinal Peptide

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503A Category 2: Bulk Drug Substances that Raise Significant Safety Risks

- Domperidone
- Quinacrine Hydrochloride for intrauterine administration
- Germanium Sesquioxide

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503A Category 3: Bulk Drug Substances Nominated Without Adequate Support

- Acetanilide
- Acidophilus Lactobacillus
- Adenosine-5-triphosphate disodium salt
- Alcloxa
- Aldioxa
- Aldosterone
- Alfalfa
- Alfalfa leaves
- Almadrate sulfate
- Aloin
- Alpha Ketoglutaric acid
- Alumina Powder, hydrated
- Aluminum phosphate
- Aminacrine Hydrochloride
- Ammonium bromide
- Ammonium hydroxide
- Anise seed
- Argentyn
- Aromatic powder
- Asafetida
- Asclepias tuberosa
- Asefetida Tincture
- Asparagus
- Aspergillus oryza enzymes
- Barosma
- Beechwood creosote
- Bean
- Betamechlomathasone
- Beta-Nicotinamide Adenine Dinucleotide Disodium Salt Trihydrate
- Bichloroacetic Acid
- Calcium Folinate
- Calcium Glycinate
- Carbazochrome
- Carbimazole
- Cedarwood Essential Oil
- Chlorhexidine Diacetate Hydrate
- Choline bitartrate
- Choline magnesium trisalicylate
- Chromium glycinate
- Coenzyme Q10
- Coenzyme Q50
- Copper
- Copper Bisglycinate
- Copper Hydrosol
- Creatine, Monohydrate
- Decylmethylsulfoxide
- Diaminopyridine (3,4-)
- Dichloroacetic acid
- Dimethyl Ketone
- Dimethylaminoethanol Bitartrate
- Dimethylglycine Hydrochloride
- Dinitrochlorobenzene
- Disodium Phosphate
-
- Edetate tetrasodium tetrahydrate
- Gamma Aminobutyric Acid
- GHRP-2
- GHRP-6
- Ginger root powder
- Ginkgo Biloba Standardized Extract
- Gluconic acid calcium salt
- Glycerol Formal
- Glydiazinamide
- Grape seed oil
- Heart-leaf nettle leaf (Urtica chamaedryoides leaf)
- Hyaluronic Acid Sodium Salt
- Hydrazine sulfate
- Indigo Carmine
- Indole-3-carbinol
- Inositol Hexanicotinate
- Iron Glycinate Chelate
- Karaya Gum
-
- L-Carnosine
- Levulose
- L-Histidine Monohydrochloride, Monohydrate
- L-Ornithin Hydrochloride
- Magnesium ascorbate
- Magnesium bisglycinate
- Magnesium bisglycinate dihydrate
- Magnesium glycinate
- Malt
- Malt soup extract
- Maltodextrin
- Manganese Bisglycinate

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- Manganese citrate
- m-cresol
- Melatonin
- Menfegol
- Meralein sodium
- Merbromin
- Mercufenol chloride
- Mercuric chloride
- Mercuric oxide
- Mercuric salicylate
- Mercuric sulfide
- Mercury
- Mercury oleate
- Mercury sulfide
- Methapyrilene fumarate
- Methoxyphenamine Hydrochloride
- Methoxypolyoxyethyleneglycol 350 laurate
- Methyl nicotinate
- Methypyrilene Hydrochloride
- Milk and molasses
- milk solids, dried
- Molasses
- Molybdenum Glycinate
- Monosodium L-Aspartate
- Mullein
- Mustard oil (alltlishthiocyanate)
- Mycozyme
- Myrrh gum tincture
- Myrrh tincture
- Natural estrogenic hormone
- Nickel-pectin
- Non-Fat Dry Milk
- Nonylphenoxypoly (ethyleneoxy) ethanol iodine
- Nonylphenoxypoly nonoxynol 9
- Noscapine Hydrochloride
- Nutmeg oil
- Nux vomica extract
- Obtundia
- Octyl triazone
- Oil of erigeron
- Organic vegetables
- Orthophosphoric acid
- Ox bile
- Ox bile extract
- Oxyquinoline
- Padimate a
- Pambron
- Pantothenic acid
- Papaya enzymes
- Papaya, natural
- Para-chloromercuriphenol
- Parethoxycaine Hydrochloride
- Parsley
- Passion flower extract
- Pennyroyal Oil
- Pentylenetetrazole
- Peppermint Oil and Sage Oil
- Pepsin
- Peruvian balsam (Myroxylon balsamum var. pereirae balsam)
- Phenacaine Hydrochloride
- Phenindamine Tartrate
- Phenolate sodium
- Phenolphthalein
- Phenoxyacetic acid
- Phenyl salicyiate (Salol)
- Phenyl salicylate
- Phenyltoloxamine dihydrogen citrate
- Phenyltoloxamine Hydrochloride
- Phosphate fluoride
- Phosphorated carbohydrate
- Phosphorus
- Phytolacca
- Picrotoxin
- Pimobendan
- Pine tar
- Piperocaine Hydrochloride
- Pipsissewa
- Piracetam dihydrogen citrate
- Piscidia erythrina
- Plantago ovata husks
- Poloxamer-iodine complex
- Polydimethylsiloxane and poloxamer
- Polyols, liquid
- Polyoxeythylene laurate

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- Potash Lye
- Potassium chlorate
- Potassium ferrocyanide
- Potassium salicylate
- Povidone-vinylacetate copolymers
- Prolase
- Prune concentrate dehydrate
- Prune powder
- Psyllium
- Psyllium hydrophillic mucilloid
- P-T-butyl-m-cresol
- Pyruvic aldehyde
- Pyruvic Aldehyde 40% Aqueous Solution
- Racephpedrine Hydrochloride
- Red petrolatum
- Reosote
- Rhubarb fluid extract
- Rhubarb, Chinese
- Rice pollishings
- Romohydrate
- Sabadilla, alkaloids
- Sage oil
- Salicyl alcohol
- Sanguinaria extract
- Saw palmetto
- Scopolamine aminoxide Hydrobromide
- Sea mineral
- Senecio aureus
- Senna syrup
- Serotonin Hydrochloride
- Sesame Seed
- Shark liver oil
- Short Chain Fatty Acid
- Silver (see also argentyn)
- Silver, colloidal
- Sodium 3, 4-dimethylphenyl-glyoxylate
- Sodium acetylsalicylate
- Sodium aluminum chlorohydroxy lactate
- Sodium aspartate
- Sodium biphosphate
- Sodium bisulfate
- Sodium borate monohydrate
- Sodium caseinate
- Sodium diacetate
- Sodium dichromate
- Sodium dihydrogen phosphate monohydrate
- Sodium nitrate
- Sodium octanoate
- Sodium oleate
- Sodium para-amino benzoate
- Sodium perborate
- Sodium perborate monohydrate
- Sodium phosphate
- Sodium potassium tartrate
- Sols, secondary
- Soy meal
- Soybean protein
- Squill preparations
- Stannous pyrophosphate and zinc citrate
- Stevia Powder Extract
- Strychnine
- Sucros
- Sugars
- Sulferated oils of turpentine
- Sulfobutylether B-Cyclodextrin
- Tannic acid glycerite
- Taraxacum officinale
- Tartrate
- Tetrahydrochloride
- Thenyldiamine Hydrochloride
- Theobromine Sodium Salicylate
- Theophylline calcium salicylate
- Thioctic
- Thiocyanoacetate
- Thonzylamine Hydrochloride
-
- Thylene blue
- Tolindate
- Toltrazuril
- Tolu preparations
- Tricalcium phosphate
- Triethanolamine
- Trillium

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- Triple dye
- Triticum
- Turpantine Oil
- Turpantine, Venice
- Uinolinium bromide
- Ulose
- Uva ursi, extract of
- Valic acid
- Vitamin A acetate
- Vitromersol
- Wheat germ
- Wheat germ (triticum aestivum/vulgare extract)
- White ointment
- Woodruff
- Yeast
- Yeast cell derivative
- Yellow mercuric oxide
- Zinc caprylate
- Zinc citrate
- Zinc phenol sulfonate
- Zinc picolinate
- Zinc propionate
- Zinc sulfide
- Zirconium oxide
- Zyloxin

Attachment 11

Interim Policy on Compounding Using Bulk Drug Substances Under Section 503B of the Federal Food, Drug, and Cosmetic Act

Guidance for Industry

U.S. Department of Health and Human Services
Food and Drug Administration
Center for Drug Evaluation and Research (CDER)
Office of Compliance/OUDLC

January 2017
Compounding and Related Documents
Revision 1

Interim Policy on Compounding Using Bulk Drug Substances Under Section 503B of the Federal Food, Drug, and Cosmetic Act

Guidance for Industry

Additional copies are available from:
Office of Communications, Division of Drug Information
Center for Drug Evaluation and Research
Food and Drug Administration
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http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm

U.S. Department of Health and Human Services
Food and Drug Administration
Center for Drug Evaluation and Research (CDER)
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January 2017
Compounding and Related Documents
Revision 1

Contains Nonbinding Recommendations

TABLE OF CONTENTS

Contains Nonbinding Recommendations

Interim Policy on Compounding Using Bulk Drug Substances Under Section 503B of the Federal Food, Drug, and Cosmetic Act Guidance for Industry[1]

This guidance represents the current thinking of the Food and Drug Administration (FDA or Agency) on this topic. It does not establish any rights for any person and is not binding on FDA or the public. You can use an alternative approach if it satisfies the requirements of the applicable statutes and regulations. To discuss an alternative approach, contact the FDA office responsible for this guidance as listed on the title page.

I. INTRODUCTION AND SCOPE

This guidance sets forth the Food and Drug Administration's (FDA or the Agency) interim regulatory policy concerning compounding by outsourcing facilities registered under section 503B of the Federal Food, Drug, and Cosmetic Act (FD&C Act or Act) [2] using bulk drug substances. Section 503B of the FD&C Act includes certain restrictions on the bulk drug substances that outsourcing facilities can use in compounding and directs FDA to develop a list of bulk drug substances that can be used in compounding under that section. FDA is developing that list of bulk drug substances (the 503B bulks list), and this guidance describes FDA's interim regulatory policy regarding outsourcing facilities that compound human drug products using bulk drug substances while the list is being developed.[3,4]

In general, FDA's guidance documents do not establish legally enforceable responsibilities. Instead, guidances describe the Agency's current thinking on a topic and should be viewed only as recommendations, unless specific regulatory or statutory requirements are cited. The use of the word *should* in Agency guidances means that something is suggested or recommended, but not required.

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[1] This guidance has been prepared by multiple offices in the Center for Drug Evaluation and Research (CDER), in consultation with the Office of Regulatory Affairs at the Food and Drug Administration.

[2] *Outsourcing facility* refers to a facility that meets the definition of an outsourcing facility under section 503B(d)(4) of the FD&C Act.

[3] This guidance does not apply to drugs compounded from bulk drug substances for use in animals. For proposed policies pertaining to compounding drug products from bulk drug substances for use in animals, see FDA's draft guidance, *Compounding Animal Drugs from Bulk Drug Substances*.

All FDA guidances are available on the FDA guidance web page. FDA updates guidances regularly. To make sure you have the most recent version of a guidance, always consult the guidance web page at http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm.

[4] FDA is also developing a separate list of bulk drug substances that can be used in compounding under section 503A of the FD&C Act. Because section 503A contains different criteria for that list and provides for a different process for its development, the section 503A bulks list is covered under a separate guidance (see guidance for industry, *Interim Policy on Compounding Using Bulk Drug Substances Under Section 503A of the Federal Food, Drug, and Cosmetic Act*).

II. BACKGROUND

A. Compounding From Bulk Drug Substances Under Section 503B

Section 503B of the FD&C Act describes the conditions that must be satisfied for human drug products compounded by an outsourcing facility to be exempt from the following three sections of the FD&C Act: section 505 (concerning the approval of drugs under new drug applications or abbreviated new drug applications); section 502(f)(1) (concerning the labeling of drugs with adequate directions for use); and section 582 (concerning drug supply chain security requirements).

One of the conditions that must be met for a drug product compounded by an outsourcing facility to qualify for these exemptions is that the outsourcing facility does not compound drug products using a bulk drug substance unless (a) it appears on a list established by the Secretary identifying bulk drug substances for which there is a clinical need, or (b) the drug compounded from such bulk drug substances appears on the drug shortage list in effect under section 506E of the FD&C Act at the time of compounding, distribution, and dispensing. Section 503B(a)(2)(A) of the FD&C Act.

A bulk drug substance is defined as meaning "the same as active pharmaceutical ingredient as defined in 21CFR 207.1(b)." See 21 CFR 207.3. Active pharmaceutical ingredient is defined as "any substance that is intended for incorporation into a finished drug product and is intended to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body," but the term "does not include intermediates used in the synthesis of the substance" (see section 503B(a)(2) and 21 CFR 207.3).[5,6]

Bulk drug substances used in compounding under section 503B must also meet certain other requirements, including: (1) if an applicable monograph exists under the United States Pharmacopeia (USP), National Formulary (NF), or another compendium or pharmacopeia recognized by the Secretary for purposes of this paragraph, the bulk drug substance complies with the monograph; (2) the bulk drug substance must be manufactured by an establishment that is registered under section 510 of the FD&C Act; and (3) the bulk drug substance must be accompanied by a valid certificate of analysis (COA). Section 503B(a)(2) of the FD&C Act.

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[5] Section 503B references the definition of bulk drug substance in FDA's drug establishment registration and listing regulations, which was codified at 21 CFR 207.3(a)(4) at the time section 503B was enacted. On August 31, 2016, FDA published a final rule in the Federal Register to update its registration and listing regulations in Part 207, which made minor changes to the definition of bulk drug substance and moved the definition to 21 CFR 207.3. The definition is also found in 207.1. *See* 81 FR 169 (August 31, 2016). Under the previous definition, bulk drug substance was defined to mean "any substance that is represented for use in a drug and that, when used in the manufacturing, processing, or packaging of a drug, becomes an active ingredient or a finished dosage form of the drug, but the term does not include intermediates used in the synthesis of such substances."

[6] Inactive ingredients are not subject to section 503B(a)(2) or the policies described in this guidance because they are not included within the definition of a bulk drug substance. *See* 21 CFR 207.3. Pursuant to section 503B(a)(3), inactive ingredients used in compounding must comply with the standards of an applicable United States Pharmacopeia or National Formulary monograph, if a monograph exists.

B. Section 503B Bulks List

1. Section 503B Bulks List History

Section 503B, added to the FD&C Act by the Drug Quality and Security Act in 2013, requires that FDA create a list of bulk drug substances for which there is a clinical need by publishing a notice in the *Federal Register* proposing bulk drug substances for inclusion on the list, providing a public comment period of 60 calendar days, and then publishing a notice in the *Federal Register* designating bulk drug substances for inclusion on the list. *See* section 503B(a)(2)(A)(i) of the FD&C Act. In the December 4, 2013, *Federal Register* (78 FR 72838), FDA published a notice inviting all interested persons to nominate bulk drug substances for inclusion on a list of bulk drug substances that can be used for compounding under section 503B of the FD&C Act.

2. Nominations for the 503B Bulks List

In response to the December 2013 *Federal Register* notice, over 2,000 substances were nominated for the 503B bulks list. However, many of the nominations for the 503B bulks list were not for substances used in compounding as active ingredients, or they did not include sufficient information to allow FDA to evaluate the nominated substances for placement on the list. To improve the efficiency of the process for developing the 503B bulks list, FDA reopened the nomination process in July 2014 (79 FR 37747), and provided more detailed information on what it needs to evaluate nominations for the list. FDA stated that bulk drug substances that were previously nominated would not be further considered unless they were re-nominated and those nominations were adequately supported. Substances that were not adequately supported would not be evaluated by FDA to be placed on the 503B bulks list. The notice stated that the following information about clinical need is necessary to provide adequate support for nominations to the 503B bulks list:

- A statement describing the medical condition(s) that the drug product to be compounded with the nominated bulk drug substances is intended to treat;
- A list of FDA-approved drug products, if any, that address the same medical condition;
- If there are any FDA-approved drug products that address the same medical condition, an explanation of why a compounded drug product is necessary;
- If the approved drug product is not suitable for a particular patient population, an estimate of the size of the population that would need a compounded drug product;
- A bibliography of safety and efficacy data for the drug product compounded using the nominated substance, if available, including any relevant peer-reviewed medical literature; and
- If there is an FDA-approved drug product that includes the bulk drug substance nominated, an explanation of why the drug product proposed to be compounded must be compounded from bulk rather than with the FDA-approved drug product.

In response to this request for nominations, approximately 2,590 unique substances were nominated. Of the nominated substances:

- Approximately 1,740 are biological products (all but one of these[7] are individual allergenic extracts) subject to approval in a biologics license application (BLA) under section 351 of the Public Health Service (PHS) Act.

These products are not eligible for the 503B bulks list because biological products subject to approval in a BLA under section 351 of the PHS Act are not eligible for the exemptions in section 503B.[8] No biological products subject to approval in a BLA will be considered for the 503B bulks list.

- At least one[9] of the nominated substances is not a bulk drug substance.

This is a finished drug product that was nominated by its brand name. Finished drug products are not eligible for the 503B bulks list because they do not meet the definition of a bulk drug substance in 21 CFR 207.3.

- At least one of the nominated substances is a radiopharmaceutical.[10]

Compounding of radiopharmaceutical products will be addressed in a separate guidance document.[11]

- At least five of the nominated substances appear on the list of drugs that have been withdrawn or removed from the market because such drug products or components of such drug products have been found to be unsafe or not effective (withdrawn or removed list)

Such substances cannot be used in compounding under section 503B of the FD&C Act, and therefore are not eligible for inclusion on the 503B bulks list.[12]

- One of the nominated substances has no currently accepted medical use and is included on Schedule I of the Controlled Substances Act (CSA) (21 U.S.C. § 812(c)).[13]

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[7] The product is sodium hexachloroplatinate (IV) hexahydrate.

[8] See the draft guidance, *Mixing, Diluting, or Repackaging Biological Products Outside the Scope of an Approved Biologics License Application* for FDA's proposed policies regarding State-licensed pharmacies, Federal facilities, and outsourcing facilities that mix, dilute, or repackage biological products outside the scope of an approved BLA.

[9] The over-the-counter finished drug product Maalox was nominated. Maalox is not a bulk drug substance.

[10] The substance is sodium iodide I-131.

[11] FDA has published a draft guidance, "Compounding and Repackaging of Radiopharmaceuticals by Outsourcing Facilities," for public comment. That draft guidance proposes the Agency's policy regarding the use of bulk drug substances to compound radiopharmaceuticals under section 503B of the FD&C Act. Once that guidance is final, FDA intends to update this guidance to reflect the policies set forth therein.

[12] See section 503B(a)(4) of the FD&C Act. See also 21 CFR 216.24. The five substances are: chloroform reagent, cobalt chloride hexahydrate, cobalt gluconate, methapyrilene fumarate, and phenacetin.

The CSA does not allow possession or distribution of Schedule I substances (see 21 U.S.C. §§ 841(a)(1) and 829), except for research purposes (21 U.S.C. § 823(f)), and these substances will not be considered for the 503B bulk drug substances list at this time. Those desiring to do research on a Schedule I substance can apply to do so under an investigational new drug application (IND).

- Of the substances that may be eligible for use in compounding under section 503B, approximately 650 substances were nominated without sufficient supporting evidence for FDA to evaluate them.

- The remaining substances that were nominated for inclusion on the 503B bulks list may be eligible for inclusion on the list and were nominated with sufficient supporting information for FDA to evaluate them. However, FDA has identified significant safety risks relating to the use in compounded drug products of some of these bulk drug substances.

FDA's website identifies the following categories of substances nominated for the 503B bulk drug substances list:[14]

503B Category 1 –Substances Nominated for the Bulks List Currently Under Evaluation: These substances may be eligible for inclusion on the 503B bulks list, were nominated with sufficient supporting information for FDA to evaluate them, and do not appear on any other list.

503B Category 2 –Substances Nominated for the Bulks List That Raise Significant Safety Risks: These substances were nominated with sufficient supporting information to permit FDA to evaluate them and they may be eligible for inclusion on the 503B bulks list. However, FDA has identified significant safety risks relating to the use of these substances in compounding pending further evaluation, and therefore does not intend to adopt the policy described for the substances in category 1. If FDA adds a substance to Category 2, it will publish a public communication (e.g. a safety alert) describing the safety risks and will post

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[13] An extract of cannabidiol (CBD) and tetrahydrocannabinol (THC) derived from marijuana (marihuana) was nominated. Marijuana (marihuana) is a Schedule I substance.

[14] http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/UCM467374.pdf. As discussed in the July 2014 Federal Register notice requesting nominations for the 503B bulks list ((79 FR 37747), nominators were to confirm that all substances nominated for the list are active ingredients that meet the definition of a "bulk drug substance." Inclusion of a substance in any of these categories does not reflect a determination by FDA that the substance is a bulk drug substance. Whether a substance is a bulk drug substance subject to the conditions in section 503B(a)(2) depends on whether it meets the definition of a bulk drug substance in 21 CFR 207.3. If the substance is used in a compounded drug as an inactive ingredient, then it does not meet the definition of a bulk drug substance in 21 CFR 207.3, is not subject to the conditions in section 503B(a)(2), and need not appear on the 503B bulks list to be eligible for use in compounding. Instead, when used as an inactive ingredient, the substance is subject to the conditions in section 503B(a)(3), which applies to ingredients other than bulk drug substances used in compounded drugs

the communication on FDA's human drug compounding website[15] advising that the substance has been added to Category 2 and is no longer eligible for the policies that apply to substances in Category 1.

503B Category 3 –Substances Nominated for the Bulks List Without Adequate Support: These substances may be eligible for inclusion on the 503B bulks list, but were nominated with insufficient supporting information for FDA to evaluate them. These substances can be re-nominated with sufficient supporting information through a docket that FDA has established, as discussed below in section III.B.

3. Process for Developing the 503B Bulks List

FDA is currently evaluating the bulk drug substances nominated for the 503B bulks list with sufficient supporting information for evaluation. FDA is considering a number of factors in prioritizing the order in which it reviews these nominated bulk drug substances, including but not limited to the following:

- Safety concerns about use of the bulk drug substance in compounding
- Whether the bulk drug substance was nominated by multiple parties or identified as necessary by medical professional organizations
- The efficiency with which the evaluation can be completed, based on ease of acquiring the necessary information to conduct the review, available resources, and other logistical issues

FDA may also group some nominated drug substances to facilitate efficient review and discussion. These include drug substances that raise similar issues (e.g., vitamins or botanicals) or that are nominated for the treatment of the same condition (e.g., warts).

FDA intends to publish a notice in the *Federal Register* that describes its proposed position on each substance it has evaluated along with the rationale for that proposal, for public comment. We note that there is no requirement in section 503B to consult the Pharmacy Compounding Advisory Committee (PCAC) before developing a 503B bulks list, as is required by section 503A(c)(1) for the 503A bulks list. However, after considering public comment on the nominated substances, FDA will determine whether PCAC input on any of the substances would be helpful to the Agency in making its determination, and if so, it will seek PCAC input. Once FDA makes a determination, it will publish in the *Federal Register* a list identifying the bulk drug substances for which it has determined there is a clinical need and FDA's rationale in making that determination. FDA will also publish in the *Federal Register* a list of those substances it considered but found that there is no clinical need to use in compounding and FDA's rationale in making this determination.

[15] http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/default.htm. FDA also encourages compounding facilities to subscribe to FDA's list serve to receive updates at: http://service.govdelivery.com/service/subscribe.html?code=USFDA_429.

Once FDA publishes a 503B bulks list in the *Federal Register* that reflects its determination regarding particular bulk drug substances, drug products compounded with substances on the 503B bulks list will be eligible for the 503B exemptions, provided the drug products are compounded in compliance with the other conditions of section 503B.[16] Once FDA has published in the *Federal Register* its decision not to place a particular substance on the 503B bulks list, the policy described in section III of this guidance no longer applies.

FDA intends to evaluate the substances nominated for the 503B list on a rolling basis. FDA will begin by publishing a *Federal Register* notice identifying a group of substances (e.g., 10 substances) that it has considered and whether it proposes the substances for inclusion on the list. Under section 503B, an outsourcing facility may only compound using bulk drug substances that are on FDA's 503B bulks list or that are used to compound drugs that appear on the shortage list in effect under section 506E of the FD&C Act at the time of compounding, distribution, and dispensing. To avoid unnecessary disruption to patient treatment while FDA considers the substances that were nominated with sufficient support to permit FDA to evaluate them, FDA is issuing this guidance stating that at this time it does not intend to take action against an outsourcing facility for failing to compound in accordance with section 503B(a)(2) if certain conditions are met. Those conditions include that the nomination for the relevant bulk drug substance was submitted with adequate information for FDA to evaluate the substance and that FDA has not identified significant safety risks about its use in compounding prior to publication of the *Federal Register* notice identifying those substances FDA has determined will or will not be placed on the 503B bulks list.

III. POLICY[17]

A. Compounding from Bulk Drug Substances Under Section 503B

Under section 503B of the FD&C Act, a bulk drug substance cannot be used in compounding unless it is used to compound a drug that appears on the FDA drug shortage list at the time of compounding, distribution, and dispensing, or it appears on the 503B bulks list.

FDA does not intend to take action against an outsourcing facility for compounding a drug product using a bulk drug substance that is not on the 503B bulks list if the drug compounded from the bulk drug substance: (i) appeared on FDA's drug shortage list within 60 days of distribution and dispensing, and (ii) was to fill an order that the outsourcing facility received for the drug while it was on FDA's drug shortage list.[18]

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[16] See section 503B(a)(11) of the FD&C Act.

[17] See Appendix A for a summary of FDA's interim policy.

[18] An outsourcing facility may not be able to predict when a drug shortage will be resolved, and the facility may have orders for a compounded drug in-house that were in progress when the drug was removed from FDA's drug shortage list (e.g., the outsourcing facility may have compounded a drug while it was in shortage, but the shortage ended while the outsourcing facility awaits the results of sterility testing before release.) This policy provides some regulatory flexibility where an outsourcing facility fills orders that it received while a drug was in shortage. However, this policy does not apply if an outsourcing facility continues to fill orders received after the shortage

In addition, at this time FDA does not intend to take action against an outsourcing facility for compounding a drug using a bulk drug substance that does not appear on the 503B bulks list and that is not used to compound a drug that appears on the FDA drug shortage list at the time of compounding, distribution, and dispensing, provided that the following conditions are met:

1. The bulk drug substance appears on 503B Category 1 on FDA's website at http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/UCM467374.pdf. A Category 1 substance may be eligible for inclusion on the 503B bulks list, was nominated for inclusion on the 503B bulks list with adequate supporting information for FDA to evaluate it, and has not been identified by FDA as a substance that appears to present a significant safety risk in compounding before a determination as to whether to place it on the 503B bulks list has been made.

2. The original manufacturer and all subsequent manufacturers of the bulk drug substance are establishments that are registered under section 510 (including foreign establishments that are registered under section 510(i)) of the FD&C Act;

3. The bulk drug substance is accompanied by a valid COA;

4. If the bulk drug substance is the subject of an applicable USP or NF monograph, the bulk drug substance complies with the monograph; and

5. The drug product compounded using the bulk drug substance is compounded in compliance with all other provisions of section 503B of the FD&C Act.

Original manufacturer means the entity that originally produced the bulk drug substance and not a subsequent packer, repacker, labeler, or distributor.

This policy does not apply to an outsourcing facility that compounds a drug using a bulk drug substance that does not meet each of the above conditions and where the bulk drug substance was not used to compound a drug that appears on the FDA drug shortage list at the time of compounding, distribution, and dispensing, or that appeared on the FDA drug shortage list within 60 days of distribution and dispensing.

B. Substances Not Nominated or Nominated Without Adequate Support

As stated above, FDA is providing a list on its website of substances nominated for the 503B bulks list that may be eligible for inclusion on the list, but that FDA is unable to evaluate for inclusion on the list at this time because the substances were nominated with insufficient supporting evidence for FDA to evaluate them (503B Category 3). In the *Federal Register* of October 27, 2015, FDA established a docket (October docket) where these substances can be re-

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ends, or if the outsourcing facility continues to fill orders more than 60 days after the drug was removed from FDA's drug shortage list.

nominated with sufficient supporting information or where nominations for substances that were not previously nominated can be submitted.

After a substance is nominated to the October docket,[19] FDA will determine whether the nomination is supported with sufficient information to allow FDA to evaluate it. After FDA makes that determination, the nominated substance will be placed in one of the three categories described in section II.B.2 above, and the categorization will be published on the FDA website. Once the category of a substance is published, FDA intends to apply the policy described in section III.A. of this guidance to that substance. FDA generally expects to categorize bulk drug substances nominated to the October docket and to publish updated categories on its website on the first business day of each month. Please note that until substances nominated for the October docket have been categorized, the policy does ***not*** apply to those substances.

C. Comments about Nominated Bulk Drug Substances

If you feel that a substance that you nominated does not appear on the appropriate list or category as described in this guidance you can submit your comment to docket number FDA-2015-N-3469. If you have new information on a previously-nominated substance that was placed in Category 3, the substance can be re-nominated with the additional information.

A nominator may also submit a comment to the docket requesting withdrawal of any of its nominations. If the party nominating the substance was the sole nominator, FDA will update the categories described in this guidance to reflect the withdrawn nomination.[20] FDA intends to provide notice to the public before removing any nominated substances from Category 1 or Category 2.

Withdrawal of a nomination upon the nominator's request, and resulting updates to the categories described in this guidance, do not reflect a determination by FDA regarding the validity of the nomination or of any reasons given by the nominator for requesting withdrawal. In addition, FDA may continue to evaluate a substance at its discretion even if the nominator submits a comment requesting withdrawal of the nomination.

[19] This includes re-nominations of substances with sufficient supporting information.

[20] If multiple parties nominated the same substance, each party that nominated the substance must withdraw its nomination for the nominated substance to be considered withdrawn and for the categories to be updated to reflect that withdrawal.

APPENDIX: SUMMARY OF POLICY

The following table summarizes the interim policy for bulk drug substances set forth in this guidance:

Category	FDA Policy
The bulk drug substance is in 503B Category 1 on FDA's website at http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/UCM467374.pdf. Such substances may be eligible for inclusion on the 503B bulks list, were nominated with adequate supporting information for FDA to evaluate them, and have not been identified by FDA as presenting significant safety risks.	The bulk drug substance is not on the 503B bulks list. However, pending a determination about whether to put the bulk drug substance on the 503B bulks list, FDA does not intend to take action against an outsourcing facility for compounding a drug product from a bulk drug substance that does not meet the conditions of section 503B(a)(2) provided that the bulk drug substance is manufactured by an establishment registered with FDA under section 510 of the FD&C Act, is accompanied by a valid COA, complies with an applicable USP monograph, if one exists, and provided that the drug compounded from the bulk drug substance is compounded in compliance with the other conditions of section 503B.
The bulk drug substance appears on the withdrawn or removed list.	The bulk drug substance cannot be used in compounding under section 503B of the FD&C Act.
The bulk drug substance is in 503B Category 2 on FDA's website at http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/UCM467374.pdf. The substance has been identified by FDA as presenting a significant safety risk in compounding pending further evaluation.	The bulk drug substance is not on the 503B bulks list, and cannot be used for compounding consistent with section 503B(a)(2) unless it is used to compound a drug that appears on FDA's drug shortage list.
The bulk drug substance is a biological product subject to approval in a BLA.	The bulk drug substance is not eligible for the 503B bulks list. FDA has issued a separate draft guidance document describing the Agency's proposed policies concerning mixing, diluting, and repackaging biological products subject to approval in a BLA.[21]
The bulk drug substance is a radiopharmaceutical product.	Compounding radiopharmaceuticals will be addressed in a separate guidance document.
The bulk drug substance is in 503B Category 3 on FDA's website at http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/UCM467374.pdf. The substance may be eligible for inclusion on the 503B bulks list but was nominated with insufficient supporting information for FDA to evaluate it.	The bulk drug substance is not on the 503B bulks list, and cannot be used for compounding consistent with section 503B(a)(2) unless the bulk drug substance is used to compound a drug that appears on FDA's drug shortage list. See section III.B of this guidance for information about supplementing inadequately supported nominations.

[21] See FDA's revised draft guidance, *Mixing, Diluting, and Repackaging Biological Products Subject to Approval in a Biologics License Application*.

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Bulk Drug Substances Nominated for Use in Compounding Under Section 503B of the Federal Food, Drug, and Cosmetic Act

503B Category 1 – Bulk Drug Substances Under Evaluation

- 17-alpha-Hydroxyprogesterone
- Acetylcysteine
- Adenosine
- Alpha Lipoic Acid
- Alprostadil
- Aluminum Chloride Hexahydrate
- Aluminum potassium sulfate
- Amitriptyline HCl
- Ascorbic acid
- Aspartic Acid
- Atenolol
- Atropine sulfate/ Atropine sulfate monohydrate
- Baclofen
- Betamethasone Acetate
- Betamethasone Sodium Phosphate
- Biotin
- Bismuth Nitrate Oxide
- Brilliant Blue
- Bromfenac sodim (for ophthalmic use)
- Brompheniramine maleate, USP
- Budesonide
- Bupivacaine Hydrochloride/ Bupivacaine Hydrochloride Monohydrate
- Caffeine
- Calcium Chloride
- Calcium EDTA
- Calcium Gluconate
- Cantharidin
- Caustic Soda (sodium hydroxide)
- Chloroquine Phosphate
- Chlorpheniramine Maleate
- Choline Bitartrate
- Choline Chloride
- Chromium chloride/ Chromium Chloride Hexahydrate
- Citric Acid Anhydrous
- Clindamycin Phosphate
- Clomipramine Hydrochloride
- Clonidine Hydrochloride
- Cyanocobalamin
- Cyclobenzaprine Hydrochloride
- Cyclopentolate
- Dapiprazole HCl
- Dexamethasone Acetate
- Dexamethasone Sodium Phosphate
- Dexpanthenol
- D-glucose
- Diazepam
- Diclofenac Sodium
- Diltiazem Hydrochloride
- Dimercapto-1-propanesulfonic acid (DMPS)
- Diphenylcyclopropenone
- Disulfiram
- Dopamine HCl
- Droperidol
- Edetate Disodium (EDTA)
- Ephedrine Hydrochloride
- Ephedrine sulfate, USP
- Epinephrine
- Epinephrine Bitartrate
- Estradiol Cypionate
- Estradiol
- Estriol
- Ethanol
- Ethyl Aminobenzoate
- Etomidate
- Famotidine
- Fentanyl Citrate
- Flurbiprofen
- Fluticasone Propionate
- Folic Acid
- Formaldehyde
- Furosemide
- Gabapentin
- Gentamicin Sulfate
- Glutamic acid
- Glutamine
- Glutathione
- Glycerin
- Glycopyrrolate/ Glycopyrrolate Bromide
- Heparin sodium

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- Hyaluronic acid sodium salt
- Hyaluronidase
- Hydralazine HCl
- Hydromorphone Hydrochloride
- Hydroxocobalamin Hydrochloride
- Hydroxyzine HCl
- Imipramine Hydrochloride
- Inositol
- Iodoform
- Itraconazole
- Ketamine Hydrochloride
- Ketoprofen
- Ketorolac Tromethamine
- Labetalol Hydrochloride
- Lansoprazole
- Lidocaine Hydrochloride
- Lincomycin HCl
- Lorazepam
- Magnesium Chloride
- Magnesium Sulfate Heptahydrate
- Malic Acid
- Medroxyprogesterone Acetate
- Meperidine Hydrochloride (a.k.a. Pethidine Hydrochloride)
- Methacholine Chloride
- Methionine/ Methionine (L)
- Methylcobalamin/ Methyl B12
- Methylprednisolone Acetate
- Methylsulfonylmethane (MSM)
- Midazolam Hydrochloride
- Mineral Oil
- Mitomycin
- Monosodium Glutamate
- Morphine Sulfate/ Morphine Sulfate Pentahydrate
- Moxifloxacin hydrochloride
- Nalbuphine HCl
- Naloxone Hydrochloride Dihydrate
- Neomycin sulfate
- Neostigmine Methylsulfate
- Niacin
- Niacinamide
- Nicardipine hydrochloride
- Nifedipine
- Norepinephrine Bitartrate
- Ondansetron HCl
- Ornithine Hydrochloride
- Oxymetazoline HCl
- Oxytocin
- Papaverine
- Phenol
- Phenoxybenzamine Hydrochloride
- Phentolamine Mesylate
- Phenylephrine HCl
- Phytonadione
- Pitcher Plant
- Podophyllum
- Polidocanol
- Polymyxin B Sulfate
- Potassium chloride
- Potassium phosphate/ Potassium Phosphate Dibasic Anhydrous
- Prednisolone
- Prednisolone Acetate
- Procainamide HCl
- Procaine Hydrochloride
- Progesterone
- Promethazine Hydrochloride
- Proparacaine HCl
- Propranolol hydrochloride
- Prostaglandin E1
- Pyridoxal 5-Phosphate Monohydrate
- Remifentanil Hydrochloride
- Riboflavin 5 PO4
- Rocuronium Bromide
- Ropivacaine Hydrochloride
- Salicylic Acid
- Scopolamine hydrobromide
- Sodium Acetate Anhydrous
- Sodium Ascorbate
- Sodium Benzoate
- Sodium Bicarbonate
- Sodium Chloride
- Sodium Citrate
- Sodium Citrate Dihydrate
- Sodium L-Aspartate Monohydrate
- Sodium phosphate/ Sodium Phosphate Monobasic Anhydrous
- Sodium Selenite
- Sodium Tetradecyl Sulfate
- Squaric acid dibutyl ester
- Succinylcholine Chloride Dihydrate
- Sufentanil Citrate
- Sulfan Blue

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- Taurine
- Testosterone
- Testosterone Propionate
- Tetracaine Hydrochloride
- Tetracycline Hydrochloride
- Thiamine HCl (vitamin B1)
- Thymol iodide
- Tramadol Hydrochloride
- Triamcinolone Acetonide
- Triamcinolone diacetate
- Tromethamine
- Tropicamide
- Trypan Blue
- Vanadium
- Vancomycin Hydrochloride
- Verapamil HCl
- Vitamin A acetate
- Vitamin D3
- Ziconotide
- Zinc Sulfate

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503B Category 2: Bulk Drug Substances that Raise Significant Safety Risks

- Germanium sesquioxide

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503B Category 3: Bulk Drug Substances Nominated Without Adequate Support

- 4-Aminopyridine
- 7-Keto Dehydroepiandrosterone, Micronized
- Acacia Gum, Spray-Dried Powder
- Acacia Syrup
- Acesulfame Potassium
- Acetanilide
- Acetic acid
- Acetone
- Acetone Sodium Bisulfite
- Acetyl Hexapeptide-3
- Acidophilus Lactobacillus
- Adenosine-5-triphosphate disodium salt
- Agar
- Alcloxa
- Aldioxa
- Aldosterone
- Alfalfa
- Alfalfa leaves
- Alginic acid
- Aliphatic Polyesters
- Allantoin
- Almadrate sulfate
- Aloin
- Alpha Ketoglutaric acid
- Alumina Powder, hydrated
- Aluminum acetate
- Aluminum chloride
- Aluminum phosphate
- Aluminum sulfate
- Aminacrine HCl
- Aminoacetic acid
- Ammonia solution, strong
- Ammonium Alginate
- Ammonium bromide
- Ammonium chloride
- Ammonium hydroxide
- Amylase
- Anise oil
- Anise seed
- Argentyn
- Arginine
- Aromatic powder
- Asafetida
- Asclepias tuberosa
- Ascrobyl Palmitate
- Asefetida Tincture
- Asparagus
- Aspartame
- Aspergillus oryza enzymes
- Attapulgite
- Azelaic Acid
- Barosma
- Basic Fuchsin
- Beachwood creosote
- Bean
- Benzalkonium Chloride
- Betamechlomathasone
- Beta-Nicotinamide Adenine Dinucleotide Disodium Salt Trihydrate
- Bethanechol
- Bichloroacetic Acid
- Bipeptide Biocosmetic
- Boric Acid
- Bromelain
- Bronopol
- Buffer Solution, pH Buffer Acid
- Butylated Hydroxytoluene
- Butylene Glycol
- Calcium Alginate
- Calcium Folinate
- Calcium glycinate
- Capsules, Empty Gelatin Vegetable
- Carbamide
- Carbazochrome
- Carbimazole
- Carbolic Acid
- Carbomer 940
- Caustic Potash
- Cedarwood Essential Oil
- Ceratonia
- Ceresin
- Cetrimide
- Chlorhexidine Diacetate Hydrate
- Choline magnesium trisalicylate
- Chondroitin Sulfate
- Chromic chloride

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- Chromium glycinate
- Chrysin
- Cidofovir
- Cocoa butter
- Coconut Oil Edible
- Coenzyme Q10
- Coenzyme Q50
- Collagenase
- Colophony
- Copper
- Copper Bisglycinate
- Copper Hydrosol
- Corn Oil
- Corn Starch
- Corn Starch and Pregelatinized Starch
- Cottonseed Oil
- Creatine, Monohydrate
- Cucumber Melon Fragrancce
- Cupric Sulfate
- Decyl Oleate
- Decylmethylsulfoxide
- Deoxy-D-Glucose
- Desonide
- Diaminopyridine (3,4-)
- Dichloroacetic Acid
- Difluoroethane
- Diindolymethane
- Dimercaptosuccinic acid
- Dimethyl Ether (aka Methoxymethane)
- Dimethyl Ketone
- Dimethyl Phthalate
- Dimethylacetamide
- Dimethylaminoethanol Bitartrate
- Dimethylaminoethanol Complex
- Dimethylglycine HCl
- Dinitrochlorobenzene
- Diphenhydramine
- Dipropylene Glycol
- Disodium Hydrogen Phosphate
- Disodium Phosphate
- DL-Phenylalanine
- Docosanol
- Dodecyl Gallate
- Domperidone
- Edetate tetrasodium tetrahydrate
- Ethanolamine
- Ethyl Lactate
- Ethylene Vinyl Acetate
- Ferric subsulfate
- Ferric sulfate hydrate
- Ferric sulfate solution
- Folinic acid calcium salt
- Formoterol Fumarate Dihydrate
- Fructose and Pregelatinized Starch
- Gamma Aminobutyric Acid
- GHRP-2
- GHRP-6
- Ginger root powder
- Ginko Biloba Standardized Extract
- Gloconic acid calcium salt
- Glutaraldehyde solution
- Glycerol Formal
- Glyceryl Monostearate
- Glyceryl Palmitostearate
- Glycofurol
- Glycolic acid
- Glydiazinamide
- Grape seed oil
- Gum Arabic
- Hectorite
- Heptafluoropropane
- Hexetidine
- Hyaluronidase, salt free
- Hydrazine sulfate
- Hydrochloric Acid
- Hydroxyethylpiperazine Ethane Sulfonic Acid
- Hydroxymethylmethyl Cellulose
- Ichthammol
- ICU Bottom Paste (Maalox)
- Indigo Carmine
- Indole-3-carbinol
- Inositol Hexanicotinate
- Iodochlorhydroxyquin
- Iopanoic Acid
- Iron Glycinate Chelate
- Isopropyl Isostearate
- Kaolin, Colloidal Powder
- Karaya Gum
- Ketoifen Fumarate
- Kojic Acid

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- Lactose Monohydrate
- Lactose, Monohydrate and Corn Starch
- Lactose, Monohydrate and Microcrystalline Cellulose
- Lactose, Monohydrate and Powdered Cellulose
- Lactose, Spray-Dried
- Lanolin, Hydrous
- L-Aspartic Acid Sodium Salt
- Lavender Oil
- L-Carnitine
- L-Carnosine
- L-Citrulline
- L-Cysteine
- Lecithin Soya Granular
- Lecithin Organogel
- Levomenthol
- Levulose
- L-Histidine Monohydrochloride, Monohydrate
- Lidocaine, Epinephrine, and Tetracaine
- Linoleic Acid
- L-Ornithin HCl
- Loxasperse
- L-Triiodothyronine Sodium
- Lysine
- Magaldrate
- Magnesium
- Magnesium aluminum silicate
- Magnesium ascorbate
- Magnesium bisglycinate
- Magnesium bisglycinate dihydrate
- Magnesium carbonate
- Magnesium citrate
- Magnesium glycinate
- Magnesium hydroxide
- Magnesium oxide
- Magnesium salicylate
- Magnesium stearate
- Magnesium sulfate
- Magnesium trisilicate
- Malt
- Malt soup extract
- Maltodextrin
- Manganese Bisglycinate
- Manganese Chloride
- Manganese citrate
- Mannitol
- Mannitol and sorbitol
- MBK
- m-cresol
- Meclizine HCl
- Medium Cream
- Menfegol
- Menthol
- Menthol/peppermint oil
- Meradimate (menthyl anthranilate)
- Meralein sodium
- Merbromin
- Mercufenol chloride
- Mercuric chloride
- Mercuric oxide
- Mercuric salicylate
- Mercuric sulfide
- Mercury
- Mercury oleate
- Mercury sulfide
- Mercury, ammoniated
- Metaproterenol sulfate
- Methenamine
- Methoxyphenamine HCl
- Methoxypolyoxyethyleneglycol 350 laurate
- Methyl nicotinate
- Methyl salicylate
- Methylbenzethoniuim chloride
- Methylcellulose
- Methylparaben
- Methypyrilene HCl
- Metoclopramide HCl
- Miconazole nitrate
- Microcrystalline Cellulose
- Milk and molasses
- Milk of sulfur
- milk solids, dried
- Mineral oil and Lanolin Alcohols
- Minerals
- Molasses
- Molybdenum Glycinate
- Mono- and di-glycerides
- Monosodium L-Aspartate
- Monosodium Phosphate
- Mullein

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- Mustard oil (alltlishthiocyanate)
- Mycozyme
- Myrrh
- Myrrh gum tincture
- Myrrh tincture
- N-Acetyl-D-Glucosamine
- Naphazoline HCl
- Natural estrogenic hormone
- Neohesperidine Dihydrochalcone
- Nettle
- Nickel-pectin
- Nicotinamide
- Nicotinic Acid
- Nitromersol
- Non-Fat Dry Milk
- Nonylphenoxypoly (ethyleneoxy) ethanol iodin
- Nonylphenxypoly nonoxynol 9
- Noscapine
- Noscapine HCl
- Nutmeg oil
- Nux vomica extract
- Nystatin
- Obtundia
- Octinoxate
- Octisalate
- Octocrylene
- Octoxynol 9
- Octyl Gallate
- Octyl triazone
- Oil of erigeron
- Opium powder
- Opium tincture
- Organic vegetables
- Orthophosphoric acid
- Ox bile
- Ox bile extract
- Oxitriptan
- Oxybenzone
- Oxyquinoline
- Oxytetracycline HCl
- Padimate a
- Padimate o
- Pambron
- Pancreatin
- Pancrelipase
- Panthenol
- Pantothenic acid
- Papain
- Papaya enzymes
- Papaya, natural
- Para-chloromercuriphenol
- Paraffin
- Paregoric
- Parethoxycaine HCl
- Parsley
- Passion flower extract
- Patchouli Essential Oil
- Pectin
- Pennyroyal Oil
- Pentylenetetrazole
- Peppermint
- Peppermint Oil
- Peppermint Spirit
- Pepsin
- Peruvian Balsam
- Petrolatum
- Phenacaine HCl
- Phenindamine Tartrate
- Pheniramine Maleate
- Phenobarbital
- Phenolate sodium
- Phenolphthalein
- Phenoxyacetic acid
- Phenyl salicylate
- Phenylalanine
- Phenylephrine bitratrate
- Phenylmercuric Borate
- Phenylmercuric cetate
- Phenylmercuric nitrate
- Phenylpropanolamine bitatrate
- Phenylpropanolamine HCl
- Phenylpropanolamine maleate
- Phenyltoloxamine citrate
- Phenyltoloxamine dihydrogen citrate
- Phenyltoloxamine HCl
- Phosphate fluoride
- Phosphorated carbohydrate
- Phosphoric acid
- Phosphorus
- Phytolacca

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- Picrotoxin
- Pilocarpine Nitrate
- Pimobendan
- Pine tar
- Pineapple enzymes
- Piperazine citrate
- Piperocaine HCl
- Piperonyl butoxide
- Pipsissewa
- Piracetam
- Piracetam dihydrogen citrate
- Piscidia erythrina
- Plantago ovata husks
- Plantago seed
- Poloxamer
- Poloxamer-iodine complex
- Poly (DL-Lactic Acid)
- Poly(methyl vinyl ether/maleic anhydride)
- Polycarbophil
- Polydimethylsiloxane and poloxamer
- Polyethylene Glycol 1450
- Polyethylene Glycol 300
- Polyethylene Glycol 400
- Polyethylene Glycol 6000
- Polyols, liquid
- Polyoxeythylene laurate
- Polysorbate 20
- Polysorbate 80
- Polyvinyl alcohol
- Potash Lye
- Potassium Acetate
- Potassium bicarbonate
- Potassium bitartrate
- Potassium bromide
- Potassium carbonate
- Potassium chlorate
- Potassium citrate
- Potassium ferrocyanide
- Potassium guaiacolsulfonate
- Potassium hydroxide
- Potassium iodide
- Potassium nitrate
- Potassium salicylate
- Povidone
- Povidone-iodine
- Povidone-vinylacetate copolymers
- Powdered Cellulose
- Pracasil Plus
- Pramoxine HCl
- Precipitated sulfur
- Pregnenolone micronized
- Prolase
- Propionic acid
- Propylene glycol
- Propylhexedrine
- Propylparaben
- Protease
- Protein hydrolysate
- Protirelin
- Prune concentrate dehydrate
- Prune powder
- Pseudoephedrine HCl
- Pseudoephedrine Sulfate
- Psyllium
- Psyllium hydrophilic mucilloid
- Psyllium seed
- P-T-butyl-m-cresol
- Pyrantel pamoate
- Pyrethrum extract
- Pyridoxine
- Pyridoxine HCl
- Pyrilamine maleate
- Pyrithione zinc
- Pyrrolidone
- Pyruvic Aldehyde 40% Aqueous Solution
- Quinine
- Racemethionine
- Racephpedrine HCl
- Raffinose
- Red petrolatum
- Reosote (Creosote?)
- Resorcinol
- Resorcinol monoacetate
- Resveratrol
- Retinoic Acid-All Trans
- Rhubarb fluid extract
- Rhubarb, Chinese
- Rice polishings
- Romohydrate
- Sabadilla, alkaloids

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- Saccharin
- Sage Oil
- Salicyl alcohol
- Salicylamide
- Salsalate
- Sanguinaria extract
- Saponite
- Saw palmetto
- Scopolamine aminoxide HBr
- Scopolamine HBr
- Sea mineral
- Secretin, human 99%
- Selenium
- Selenium sulfide
- Senecio aureus
- Senna
- Senna fluid extract
- Senna pod concentrate
- Senna syrup
- Sennosides a and b
- Serotonin HCl
- Sesame Oil
- Sesame Seed
- Shark liver oil
- Shea Butter, Organic
- Short Chain Fatty Acid
- Silver Bulk Drug Substance
- Silver nitrate
- Silver protein mild
- Silver, colloidal
- Silver[1] (Canadian_License_Sovereign_)
- Simethicone
- Simplgel 30
- Sincalide
- Skin protectant
- Sodium
- Sodium 3, 4-dimethylphenyl-glyoxylate
- Sodium acetylsalicylate
- Sodium aluminum chlorohydroxy lactate
- Sodium aspartate
- Sodium biphosphate
- Sodium bisulfate
- Sodium borate
- Sodium borate monohydrate
- Sodium bromide
- Sodium caprylate
- Sodium carbonate
- Sodium carboxymethylcellulose
- Sodium caseinate
- Sodium diacetate
- Sodium dichromate
- Sodium dihydrogen phosphate
- Sodium dihydrogen phosphate monohydrate
- Sodium fluoride
- Sodium hyaluronate
- Sodium monofluoro phosphate
- Sodium nitrate
- Sodium octanoate
- Sodium oleate
- Sodium para-amino benzoate
- Sodium perborate
- Sodium perborate monohydrate
- Sodium phosphate dibasic
- Sodium phosphate monobasic
- Sodium potassium tartrate
- Sodium priopionate
- Sodium salicylate
- Sodium sulfide
- Sodium thiosulfate
- Soft Paraffin
- Sols, secondary
- Sorbitol
- Soy meal
- Soybean oil
- Soybean protein
- Splenda
- Squill preparations
- Stannous fluoride
- Stannous pyrophosphate
- Stearyl alcohol
- Stem bromelain
- Stevia Powder Extract
- Strawberry
- Strontium chloride
- Strychnine
- Sublimed sulfur
- Succinylcholine chloride, USP
- Sucrose
- Sugars
- Sulfacetamide sodium

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- Sulferated oils of turpentine
- Sulfobutylether B-Cyclodextrin
- Sulfur
- Sulisobenzone
- Supposibase-F
- T3 Sodium Dilution
- Talc
- Tannic acid
- Tannic acid glycerite
- Taraxacum officinale
- Tartaric acid
- Tartrate
- Tea Tree Oil
- Teaberry Oil
- Terpin hydrate preparations
- Testosterone cypionate, USP
- Tetrafluoroethane
- Tetrahydrochloride
- Thaumatin
- Thenyldiamine HCl
- Theobromine Sodium Salicylate
- Theophylline calcium salicylate
- Theophylline sodium glycinate
- Theophylline, anhydrous
- Theophylline, USP
- Theophyllline compound with ethylenediamine
- Thiamine mononitrate (vitamin B1)
- Thimerosal
- Thioctic
- Thiocyanoacetate
- Thonzylamine HCl
- Threonine
- Thylene blue
- Thymol
- Titanium dioxide
- Tolindate
- Tolnaftate
- Toltrazuril
- Tolu balsam
- Tommy gel
- Topical starch
- Tranilast
- Triacetin
- Tricalcium phosphate
- Tricaprylin
- Trichloroacetic Acid
- Triclocarban
- Triclosan
- Triethanolamine
- Triglycerides
- Trillium
- Trilostane
- Triolein
- Tripelennamine HCl
- Triple dye
- Triprolidine HCl
- Triticum
- Trolamine salicylate (triethanolamine salicylate)
- Tryptophan
- Turpantine Oil
- Turpantine, Venice
- Tyrosine
- Uinolinium bromide
- Ulose
- Undecoylium chlorideiodine complex
- Undecylenic acid
- Urea
- Uva ursi, extract of
- Valic acid
- Valine
- Vitamin A palmitate
- Vitamin E
- Vitromersol
- Water and additives
- Water, purified
- Wax, Anionic Emulsifying
- Wax, white
- Wax, yellow
- Wheat germ
- White ointment
- White petrolatum
- Witch hazel (hamamelis water)
- Witch hazel skin
- Woodruff
- Xanthan gum
- Xylometazoline HCl
- Yeast
- Yeast cell derivative
- Yellow mercuric oxide
- Zinc

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- Zinc acetate
- Zinc caprylate
- Zinc carbonate
- Zinc chloride
- Zinc citrate
- Zinc oxide
- Zinc phenol sulfonate
- Zinc picolinate
- Zinc propionate
- Zinc pyrithione
- Zinc stearate
- Zinc sulfide
- Zinc undecylenate
- Zirconium oxide
- Zyloxin

Attachment 12

#230

Guidance for Industry
Compounding Animal Drugs from Bulk Drug Substances

DRAFT GUIDANCE

This guidance document is being distributed for comment purposes only.

Comments and suggestions regarding this draft document should be submitted within 90 days of publication in the *Federal Register* of the notice announcing the availability of the draft guidance. Submit electronic comments to http://www.regulations.gov. Submit written comments to the Division of Dockets Management (HFA-305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. All comments should be identified with the docket number listed in the notice of availability that publishes in the *Federal Register*.

For questions regarding this draft document, contact Eric Nelson (CVM) at 240-402-5642, or by e-mail at eric.nelson@fda.hhs.gov.

U.S. Department of Health and Human Services
Food and Drug Administration
Center for Veterinary Medicine (CVM)

May 2015

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Contains Nonbinding Recommendations

Draft — Not for Implementation

Guidance for Industry[1]

Compounding Animal Drugs from Bulk Drug Substances

This draft guidance, when finalized, represents the Food and Drug Administration's (FDA or Agency) current thinking on this topic. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. You can use an alternative approach if the approach satisfies the requirements of the applicable statutes and regulations. If you want to discuss an alternative approach, contact the FDA staff responsible for implementing this draft guidance using the contact information on the title page of this guidance.

I. INTRODUCTION AND SCOPE

This draft guidance sets forth the Food and Drug Administration's ("FDA") policy regarding compounding animal drugs from bulk drug substances[2] by state-licensed pharmacies, licensed veterinarians, and facilities that register with FDA as outsourcing facilities under section 503B of the Federal Food, Drug, and Cosmetic Act (FD&C Act) (21 U.S.C. 353b). This guidance reflects FDA's current thinking regarding compounding animal drugs from bulk drug substances and describes the conditions under which FDA generally does not intend to take action for violations of the following sections of the FD&C Act: section 512 (21 U.S.C. 360b), section 501(a)(5) (21 U.S.C. 351(a)(5)), section 502(f)(1) (21 U.S.C. 352 (f)(1)), and, where specified, section 501(a)(2)(B) (21 U.S.C 351(a)(2)(B)), when a state-licensed pharmacy, licensed veterinarian, or an outsourcing facility[3] compounds animal drugs from bulk drug substances.

This draft guidance only addresses the compounding of animal drugs from bulk drug substances. It does not apply to the compounding of animal drugs from approved new animal or new human drugs. Such compounding can be conducted in accordance with the provisions of section 512(a)(4) and (5) of the FD&C Act (21 U.S.C. 360b(a)(4) and (5)) and 21 CFR part 530. In addition, this draft guidance does not address the compounding of drugs intended for use in

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[1] This draft guidance has been prepared by the Center for Veterinary Medicine (CVM) in consultation with the Center for Drug Evaluation and Research (CDER) and the Office of Regulatory Affairs (ORA) at the Food and Drug Administration.

[2] FDA regulations define "bulk drug substance" as "any substance that is represented for use in a drug and that, when used in the manufacturing, processing, or packaging of a drug, becomes an active ingredient or a finished dosage form of the drug, but the term does not include intermediates used in the synthesis of such substances." 21 CFR 207.3(a)(4). "Active ingredient" is defined as "any component that is intended to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body of man or other animals. The term includes those components that may undergo chemical change in the manufacture of the drug product and be present in the drug product in a modified form intended to furnish the specified activity or effect." 21 CFR 210.3(b)(7). Any component other than an active ingredient is an "inactive ingredient." See 21 CFR 210.3(b)(8). Inactive ingredients used in compounded drug products commonly include flavorings, dyes, diluents, or other excipients.

[3] "Outsourcing facility" refers to a facility that meets the definition of an outsourcing facility under section 503B(d)(4) of the FD&C Act. See draft guidance for industry *For Entities Considering Whether to Register As Outsourcing Facilities Under Section 503B of the Federal Food, Drug, and Cosmetic Act*. http://www.fda.gov/ucm/groups/fdagov-public/@fdagov-drugs-gen/documents/document/ucm434171.pdf.

humans, which is addressed in other guidances.[4] Further, the draft guidance does not address new animal drugs for investigational use. See 21 CFR part 511.

FDA's guidance documents, including this draft guidance, do not establish legally enforceable responsibilities. Instead, guidances describe FDA's current thinking on a topic and should be viewed only as recommendations, unless specific regulatory or statutory requirements are cited. The use of the word *should* in FDA guidances means that something is suggested or recommended, but not required.

II. BACKGROUND

A. Regulatory Framework

To be legally marketed, new animal drugs must be approved under section 512 of the FD&C Act, conditionally approved under section 571 of the FD&C Act (21 U.S.C. 360ccc), or included on the Index of Legally Marketed Unapproved New Animal Drugs for Minor Species under section 572 of the FD&C Act (21 U.S.C. 360ccc-1). The FD&C Act does not generally distinguish between compounding and other methods of animal drug manufacturing. Animal drugs that are not approved or indexed are considered "unsafe" under section 512(a)(1) of the FD&C and adulterated under section 501(a)(5) of the FD&C Act.

Although sections 503A (21 U.S.C. 353a) and 503B of the FD&C Act provide certain statutory exemptions for compounded human drugs, these sections do not provide exemptions for drugs compounded for animal use. The compounding of an animal drug from bulk drug substances results in a new animal drug that must comply with the FD&C Act's approval/indexing requirements.[5] Further, all animal drugs are required to, among other things, be made in accordance with current good manufacturing practice (cGMP) requirements (section 501(a)(2)(B)) of the FD&C Act and 21 CFR parts 210 and 211) and have adequate directions for use (section 502(f)(1) of the FD&C Act).

Sections 512(a)(4) and (5) of the FD&C Act provide a limited exemption from certain requirements for compounded animal drugs made from already approved animal or human drugs. Such use is considered an extralabel use and the FD&C Act provides an exemption from the approval requirements and requirements of section 502(f) of the FD&C Act for extralabel uses that meet the conditions set out in the statute and FDA regulations at 21 CFR part 530. Among other things, these regulations specify that nothing in the regulations should be construed as permitting compounding animal drugs from bulk drug substances.

In 1996, FDA announced the availability of a CPG (section 608.400) entitled, "Compounding of Drugs for Use in Animals" (61 FR 34849, July 3, 1996), to provide guidance to FDA's field and headquarters staff with regard to the compounding of animal drugs by veterinarians and pharmacists. An updated CPG was made available on July 14, 2003 (68 FR 41591). This draft guidance supersedes that CPG, which has now been withdrawn.

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[4] http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/ucm166743.htm.

[5] See *Medical Center Pharmacy v. Mukasey*, 536 F.3d 383, 394 (5th Cir. 2008).

B. Compounding Animal Drugs

Numerous drugs are approved or indexed for use in animals. However, there are many different species of animals with different diseases and conditions for which there are no approved or indexed animal drugs. In some cases, approved human drugs can be used to treat an animal under the extralabel use provisions of the FD&C Act and FDA regulations (sections 512(a)(4) and (a)(5) of FD&C Act and 21 CFR part 530). For example, various chemotherapeutic drugs approved for humans are used to treat cancer in dogs and cats. FDA recognizes that there are circumstances where there is no drug available to treat a particular animal with a particular condition, because either no drug is approved for a specific animal species or no drug is available under the extralabel drug use provisions. In those limited circumstances, an animal drug compounded from bulk drug substances may be an appropriate treatment option.

However, FDA is concerned about the use of animal drugs compounded from bulk drug substances, especially when approved alternatives exist that can be used as labeled or in an extralabel manner consistent with the requirements of FDA's extralabel provisions. Compounded drugs have not undergone premarket FDA review of safety, effectiveness, or manufacturing quality. The unrestricted compounding of animal drugs from bulk drug substances has the potential to compromise food safety, place animals or humans at undue risk from unsafe or ineffective treatment, and undermine the incentives to develop and submit new animal drug applications to FDA containing data and information to demonstrate that the product is safe, effective, properly manufactured, and accurately labeled.

III. POLICY

As discussed above, animal drugs are generally subject to the adulteration, misbranding, and approval provisions of the FD&C Act. Generally, FDA does not intend to take action under sections 512(a), 501(a)(5), 502(f)(1) and 501(a)(2)(B) of the FD&C Act if a state-licensed pharmacy or a licensed veterinarian compounds animal drugs from bulk drug substances in accordance with the conditions described below, and the drug is not otherwise adulterated or misbranded. In addition, FDA generally does not intend to take action under sections 512(a), 501(a)(5), and 502(f)(1) of the FD&C Act if an outsourcing facility compounds animal drugs in accordance with all of the applicable conditions described below, and the drug is not otherwise adulterated or misbranded.

FDA's decision not to take enforcement action depends on its ability to evaluate whether the compounding of animal drugs is in accordance with the conditions below. Therefore, entities compounding animal drugs should keep adequate records to demonstrate that they are compounding such drugs in accordance with all of the applicable conditions described below.

The conditions referred to above are as follows:

A. If the animal drug is compounded in a state-licensed pharmacy:

1. The drug is compounded by or under the direct supervision of a licensed pharmacist.

2. The drug is dispensed after the receipt of a valid prescription from a veterinarian for an individually identified animal patient that comes directly from the prescribing veterinarian or from the patient's owner or caretaker to the compounding pharmacy. A drug may be compounded in advance of receipt of a prescription in a quantity that does not exceed the amount of drug product that the state-licensed pharmacy compounded pursuant to patient-specific prescriptions based on a history of receipt of such patient-specific prescriptions for that drug product over any consecutive 14-day period within the previous 6 months.

3. The drug is not intended for use in food-producing animals, and the prescription or documentation accompanying the prescription for the drug contains the statement "This patient is not a food-producing animal." For purposes of this draft guidance, all cattle, swine, chicken, turkey, sheep, goats, and non-ornamental fish are always considered to be food-producing animals regardless of whether the specific animal or food from the specific animal is intended to be introduced into the human or animal food chain (e.g., pet pot-bellied pigs and pet chicks are always considered to be food-producing animals). In addition, for purposes of this draft guidance, any other animal designated on the prescription or in documentation accompanying the prescription by the veterinarian as a food-producing animal, regardless of species, is considered to be a food-producing animal (e.g., rabbits, captive elk, captive deer).

4. If the drug contains a bulk drug substance that is a component of any marketed FDA-approved animal or human drug:

    a. there is a change between the compounded drug and the comparable FDA-approved animal or human drug made for an individually identified animal patient that produces a clinical difference for that individually identified animal patient, as determined by the veterinarian prescribing the compounded drug for his/her patient under his/her care, and
    b. the prescription or documentation accompanying the prescription contains a statement that the change between the compounded drug and the FDA-approved drug would produce a clinical difference for the individually identified animal patient. For example, the veterinarian could state that, "Compounded drug X would produce a clinical difference for the individually identified animal patient because the approved drug is too large a dose for the animal and cannot be divided or diluted into the small dose required."

5. If there is an FDA-approved animal or human drug with the same active ingredient(s), the pharmacy determines that the compounded drug cannot be made from the FDA-approved drug(s), and documents that determination.

6. The pharmacy receives from the veterinarian (either directly or through the patient's owner or caretaker), in addition to any other information required by state law, the following information, which can be documented on the prescription or documentation accompanying the prescription:

    a. Identification of the species of animal for which the drug is prescribed; and,
    b. The statement "There are no FDA-approved animal or human drugs that can be used as labeled or in an extralabel manner under section 512(a)(4) or (5) and 21 CFR part 530 to appropriately treat the disease, symptom, or condition for which this drug is being prescribed."

7. Any bulk drug substance used to compound the drug is manufactured by an establishment that is registered under section 510 of the FD&C Act (21 U.S.C. 360) (including a foreign establishment that is registered under section 510) and is accompanied by a valid certificate of analysis.

8. The drug is compounded in accordance with Chapters <795> and <797> of the United States Pharmacopeia and National Formulary (USP—NF)[6] (e.g., a sterile drug is compounded in an area with air quality that meets or exceeds ISO Class 5 standards (see USP—NF Chapter <797>, Table 1)).

9. The drug is not sold or transferred by an entity other than the entity that compounded such drug. For purposes of this condition, a sale or transfer does not include administration of a compounded drug by a veterinarian to a patient under his or her care.

10. Within 15 days of becoming aware of any product defect or serious adverse event associated with animal drugs it compounded from bulk drug substances, the pharmacy reports it to FDA on Form FDA 1932a. Form FDA 1932a can be downloaded at http://www.fda.gov/downloads/aboutfda/reportsmanualsforms/forms/animaldrugforms/ucm048817.pdf.

11. The label of any compounded drug indicates the species of the intended animal patient, the name of the animal patient and the name of the owner or caretaker of the animal patient.

B. If the animal drug is compounded by a licensed veterinarian:

1. The drug is compounded and dispensed by the veterinarian to treat an individually identified animal patient under his or her care.

[6] Chapters <795> *Pharmaceutical Compounding—Nonsterile Preparations* and <797> *Pharmaceutical Compounding—Sterile Preparations* can be found in the combined *United States Pharmacopeia and National Formulary (USP-NF)*, available at http://www.usp.org.

2. The drug is not intended for use in food-producing animals as defined in section III.A.3 of this guidance.

3. If the drug contains a bulk drug substance that is a component of any marketed FDA-approved animal or human drug, there is a change between the compounded drug and the comparable FDA-approved animal or human drug made for an individually identified animal patient that produces a clinical difference for that individually identified animal patient, as determined by the veterinarian prescribing the compounded drug for his/her patient under his/her care.

4. There are no FDA-approved animal or human drugs that can be used as labeled or in an extralabel manner under sections 512(a)(4) and (5) of the FD&C Act and 21 CFR part 530 to appropriately treat the disease, symptom, or condition for which the drug is being prescribed.

5. The drug is compounded in accordance with USP—NF Chapters <795> and <797> (e.g., a sterile drug is compounded in an area with air quality that meets or exceeds ISO Class 5 standards (see USP—NF Chapter <797>, Table 1)).

6. Any bulk drug substance used is manufactured by an establishment that is registered under section 510 of the FD&C Act (21 U.S.C. 360) (including a foreign establishment that is registered under section 360(i)) and is accompanied by a valid certificate of analysis.

7. The drug is not sold or transferred by the veterinarian compounding the drug. For purposes of this condition, a sale or transfer does not include administration of a compounded drug by the veterinarian to a patient under his or her care, or the dispensing of an animal drug compounded by the veterinarian to the owner or caretaker of an animal under his or her care.

8. Within 15 days of becoming aware of any product defect or serious adverse event associated with animal drugs the veterinarian compounded from bulk drug substances, he or she reports it to FDA on Form FDA 1932a. Form FDA 1932a can be downloaded at http://www.fda.gov/downloads/aboutfda/reportsmanualsforms/forms/animaldrugforms/ucm048817.pdf.

9. The label of any compounded drug indicates the species of the intended animal patient, the name of the animal patient and the name of the owner or caretaker of the animal patient.

C. If the animal drug is compounded by an outsourcing facility:

1. The drugs are compounded only from bulk drug substances appearing on Appendix A of this draft guidance.

2. The drug is compounded by or under the direct supervision of a licensed pharmacist.

3. The drug is not intended for use in food-producing animals, as defined in Section III.A.3 of this guidance, and the prescription or order, or documentation accompanying the prescription or order, for the drug contains the statement, "This drug will not be dispensed for or administered to food-producing animals."

4. The drug is compounded in accordance with cGMP requirements.[7]

5. Any bulk drug substance used is manufactured by an establishment that is registered under section 510 of the FD&C Act (21 U.S.C. 360) (including a foreign establishment that is registered under section 360(i)) and is accompanied by a valid certificate of analysis.

6. The drug is not sold or transferred by an entity other than the outsourcing facility that compounded such drug. For purposes of this condition, a sale or transfer does not include administration of a compounded drug by a veterinarian to a patient under his or her care.

7. Within 15 days of becoming aware of any product defect or serious adverse event associated with animal drugs it compounded from bulk drug substances, the outsourcing facility reports it to FDA, on Form FDA1932a. Form FDA 1932a can be downloaded at http://www.fda.gov/downloads/aboutfda/reportsmanualsforms/forms/animaldrugforms/ucm048817.pdf.

8. All drugs compounded for animals by an outsourcing facility are included on the report required by section 503B of the FD&C Act to be submitted to the Food and Drug Administration each June and December identifying the drugs made by the outsourcing facility during the previous 6-month period, and providing the active ingredient(s); source of the active ingredient(s); NDC number of the source ingredient(s), if available; strength of the active ingredient(s) per unit; the dosage form and route of administration; the package description; the number of individual units produced; and the NDC number of the final product, if assigned.[8] The outsourcing facility should identify which reported drugs were intended for animal use.

9. The veterinarian's prescription or order states that the drug is intended to treat the species and condition(s) for which the substance is listed in Appendix A.

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[7] FDA intends to determine whether this condition is met by evaluating whether the facility complies with FDA regulations applicable to cGMPs for compounding of human drugs by outsourcing facilities. *See, e.g.*, draft guidance for industry, *Current Good Manufacturing Practice—Interim Guidance for Human Drug Compounding Outsourcing Facilities Under Section 503B of the FD&C Act* (July 2014), at http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM403496.pdf

[8] FDA has issued a draft guidance for industry, *Electronic Drug Product Reporting for Human Drug Compounding Outsourcing Facilities Under Section 503B of the Federal Food, Drug, and Cosmetic Act* (November 2014), which prescribes how human drug compounding facilities are to submit drug product reports to FDA. Available at http://www.fda.gov/downloads/Drugs/NewsEvents/UCM424303.pdf. Although this guidance addresses reporting of compounded human drug products, outsourcing facilities should follow the same procedure to electronically report the animal drug products they compounded.

10. The label of the drug includes the following:

    a. Active ingredient(s).
    b. Dosage form, strength, and flavoring, if any.
    c. Directions for use, as provided by the veterinarian prescribing or ordering the drug.
    d. Quantity or volume, whichever is appropriate.
    e. The statement "Not for resale."
    f. The statement "For use only in [fill in species and any associated condition or limitation listed in Appendix A]."
    g. The statement "Compounded by [name of outsourcing facility]."
    h. Lot or batch number of drug.
    i. Special storage and handling instructions.
    j. Date the drug was compounded.
    k. Beyond use date (BUD) of the drug.
    l. Name of veterinarian prescribing or ordering the drug.
    m. The address and phone number of the outsourcing facility that compounded the drug.
    n. Inactive ingredients.
    o. The statement "Adverse events associated with this compounded drug should be reported to FDA on a Form FDA 1932a."
    p. If the drug is compounded pursuant to a patient specific prescription, the species of the animal patient, name of the animal patient, and name of the owner or caretaker of the animal patient.

APPENDIX A[9]

LIST OF BULK DRUG SUBSTANCES THAT MAY BE USED BY AN OUTSOURCING FACILITY TO COMPOUND DRUGS FOR USE IN ANIMALS

This Appendix, when finalized, will contain a list of bulk drug substances that may be used by facilities registered under section 503B as outsourcing facilities to compound animal drugs pursuant to a prescription from a veterinarian for an individually identified animal patient or pursuant to an order from a licensed veterinarian for veterinarian office use, and in accordance with any specified limitations or conditions.

This list will be developed with public input; the process for nominating bulk drug substances for this list is described in the Federal Register notice soliciting nominations for such bulk drug substances. FDA intends to limit the bulk drug substances in this Appendix to address situations where all of the following criteria are met:

- there is no marketed approved, conditionally approved, or index listed animal drug that can be used as labeled to treat the condition;
- there is no marketed approved animal or human drug that could be used under section 512(a)(4) or (a)(5) and 21 CFR Part 530 (addressing extralabel use of approved animal and human drugs) to treat the condition;
- the drug cannot be compounded from an approved animal or human drug;
- immediate treatment with the compounded drug is necessary to avoid animal suffering or death; and
- FDA has not identified a significant safety concern specific to the use of the bulk drug substance to compound animal drugs (under the listed conditions and limitations).

FDA intends to review the nominated bulk drug substances on a rolling basis and to periodically update this Appendix.

LIST:

[9] To submit nominations for this list, refer to the Federal Register notice entitled, "List of Bulk Drug Substances That May be Used by an Outsourcing Facility to Compound Drugs for Use in Animals," published May 19, 2015**.** After the period for nominations closes, you may petition FDA under 21 CFR 10.30 to add or remove specific listings.

Attachment 13

Board of Pharmacy Enforcement Statistics
Fiscal Year 2016/2017

Workload Statistics	July-Sept	Oct-Dec	Jan-Mar	Apr-June	Total 16/17
Complaints/Investigations					
Received	792	659	780		2231
Closed	790	623	956		2369
4301 letters	4	9	8		21
Pending (at the end of quarter)	2441	2459	2241		2241
Cases Assigned & Pending (by Team) at end of quarter*					
Compliance / Routine Team	1063	1158	1014		1014
Drug Diversion/Fraud	450	429	456		456
RX Abuse	171	151	172		172
Compounding	126	114	121		121
Probation/PRP	75	79	68		68
Mediation/Enforcement **	252	228	123		123
Criminal Conviction	304	300	287		287
Application Investigations					
Received	154	159	80		393
Closed					
Approved	110	71	96		277
Denied	10	15	30		55
Total ***	147	109	161		417
Pending (at the end of quarter)	111	161	86		86
Letter of Admonishment (LOA) / Citation & Fine					
LOAs Issued	114	117	139		370
Citations Issued	589	379	537		1505
Total Fines Collected ****	$447,974.15	$585,750.00	$446,932.60		$1,480,656.75

* This figure includes reports submitted to the supervisor and cases with SI awaiting assignment.

** This figure include reports submitted to the citation and fine unit, AG referral, as well as cases assigned to enf. Staff

*** This figure includes withdrawn applications.

****Fines collected (through 3/31/2017 and reports in previous fiscal year.)

Board of Pharmacy Enforcement Statistics
Fiscal Year 2016/2017

Workload Statistics	July-Sept	Oct-Dec	Jan-Mar	Apr-June	Total 16/17
Administrative Cases (by effective date of decision)					
Referred to AG's Office*	105	68	79		252
Accusations Filed	73	56	70		199
Statement of Issues Filed	5	7	7		19
Petitions to Revoke Filed	4	0	3		7
Pending					
Pre-accusation	255	240	218		218
Post Accusation	278	252	241		241
Total*	573	519	490		490
Closed					
Revocation					
Pharmacist	4	2	5		11
Intern Pharmacist	1	0	0		1
Pharmacy Technician	37	33	26		96
Designated Representative	0	0	1		1
Wholesaler	0	0	1		1
Sterile Compounding	0	0	1		1
Pharmacy	4	2	2		8
Revocation,stayed; suspension/probation					
Pharmacist	1	1	6		8
Intern Pharmacist	0	0	0		0
Pharmacy Technician	0	2	1		3
Designated Representative	0	0	0		0
Wholesaler	0	0	0		0
Sterile Compounding	0	0	0		0
Pharmacy	0	0	1		1
Revocation,stayed; probation					
Pharmacist	8	17	10		35
Intern Pharmacist	0	0	0		0
Pharmacy Technician	4	1	5		10
Designated Representative	0	0	0		0
Wholesaler	1	0	0		1
Sterile Compounding	0	0	1		1
Pharmacy	5	10	6		21
Surrender/Voluntary Surrender					
Pharmacist	7	8	6		21
Intern Pharmacist	0	1	0		1
Pharmacy Technician	10	10	8		28
Designated Representative	0	0	0		0
Wholesaler	0	0	0		0
Sterile Compounding	0	0	1		1
Pharmacy	3	9	9		21

Board of Pharmacy Enforcement Statistics
Fiscal Year 2016/2017

Workload Statistics	July-Sept	Oct-Dec	Jan-Mar	Apr-June	Total 16/17
Public Reproval/Reprimand					
Pharmacist	5	2	6		13
Intern Pharmacist	0	0	0		0
Pharmacy Technician	0	1	2		3
Designated Representative	0	0	0		0
Wholesaler	0	0	0		0
Sterile Compounding	0	0	0		0
Pharmacy	0	1	3		4
Licenses Granted					
Pharmacist	0	1	1		2
Intern Pharmacist	0	2	0		2
Pharmacy Technician	1	2	2		5
Designated Representative	1	0	0		1
Wholesaler	0	0	0		0
Sterile Compounding	0	0	0		0
Pharmacy	0	0	0		0
Licenses Denied					
Pharmacist	0	0	0		0
Intern Pharmacist	0	0	0		0
Pharmacy Technician	3	4	3		10
Designated Representative	0	0	0		0
Wholesaler	0	0	0		0
Sterile Compounding	0	0	0		0
Pharmacy	0	0	0		0
Cost Recovery Requested**	$307,270.00	$620,180.11	$396,277.52		$1,323,727.63
Cost Recovery Collected**	$132,381.11	$275,441.13	$299,714.67		$707,536.91

* This figure includes Citation Appeals

** This figure includes administrative penalties

Immediate Public Protection Sanctions					
Interim Suspension Order	0	0	1		1
Automatic Suspension / Based on Conviction	0	0	1		1
Penal Code 23 Restriction	2	3	3		8
Cease & Desist - Sterile Compounding	0	0	1		1

Board of Pharmacy Enforcement Statistics
Fiscal Year 2016/2017

Workload Statistics	July-Sept	Oct-Dec	Jan-Mar	Apr-June	Total 16/17
Probation Statistics					
Licenses on Probation					
Pharmacist	176	190	190		190
Intern Pharmacist	3	6	6		6
Pharmacy Technician	37	36	36		36
Designated Representative	1	1	1		1
Pharmacy	54	56	60		60
Sterile Compounding	10	10	12		12
Wholesaler	5	5	5		5
Probation Office Conferences	15	36	31		82
Probation Site Inspections	141	126	151		418
Successful Completion	5	4	12		21
Probationers Referred to AG for non-compliance	0	4	0		4

As part of probation monitoring, the board requires licensees to appear before the supervising inspector at probation office conferences. These conferences are used as 1) an orientation to probation and the specific requirements of probation at the onset, 2) to address areas of non-compliance when other efforts such as letters have failed, and 3) when a licensee is scheduled to end probation.

As of March 31, 2017.

SB 1441 – Program Statistics

Licensees with substance abuse problems who are either on board probation and/or participating in the Pharmacist Recovery Program (PRP)

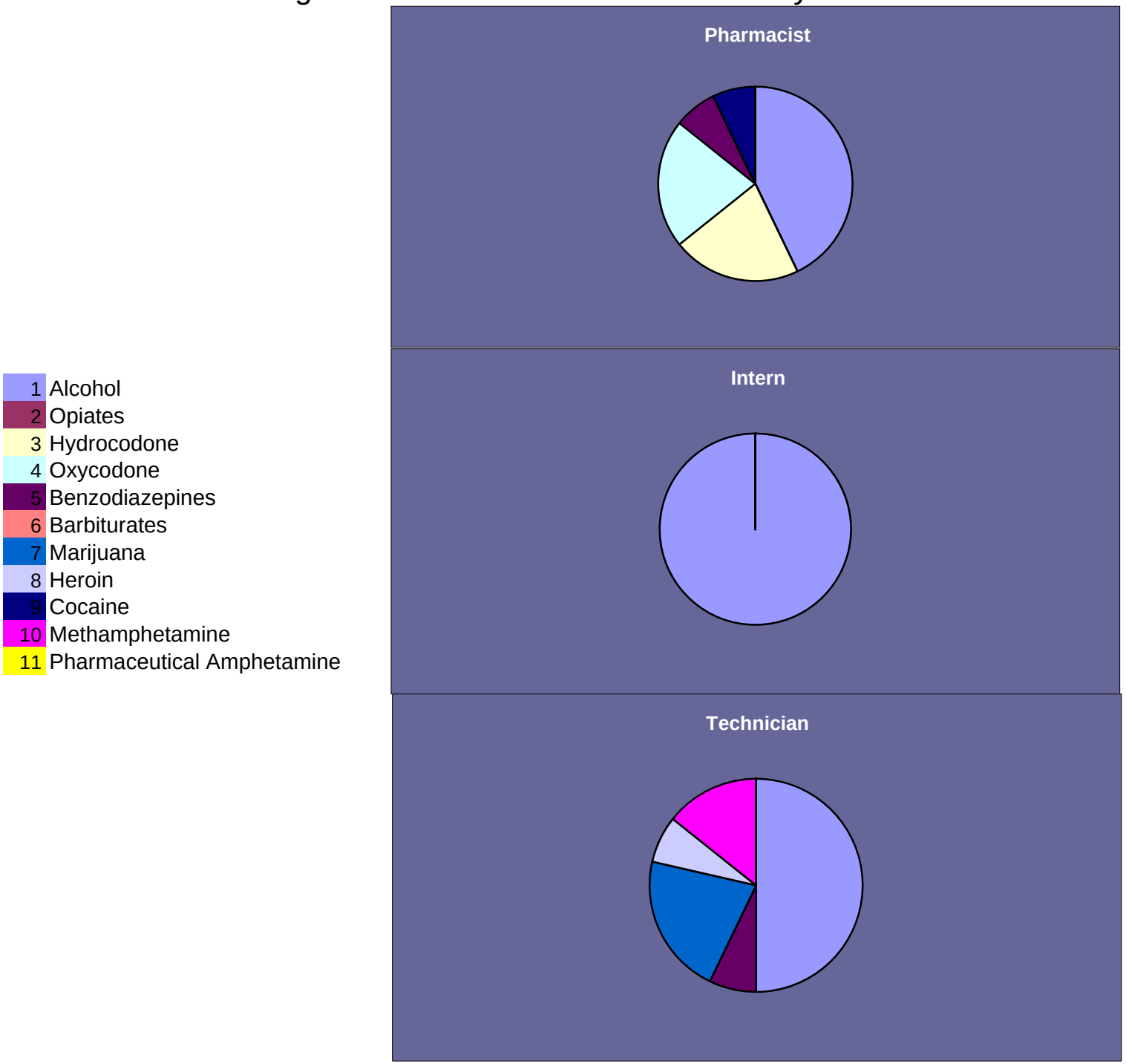
Board of Pharmacy	July -Sep	Oct – Dec	Jan-Mar	Apr-Jun	Total 16/17
PRP Intakes					
PRP Self-Referrals					
PRP Board Referrals		3	3		6
PRP Under Investigation	3	1	1		5
PRP In Lieu Of					
Total Number of PRP Intakes	3	4	4		11
New Probationers					
Pharmacists	2	2	4		8
Interns		2			2
Technicians	2	4	5		11
Total New Probationers	4	8	9		21
PRP Participants and Contracts					
Total PRP Participants	53	55	56		N/A
Contracts Reviewed	50	47	49		146
Probationers and Inspections					
Total Probationers	81	83	82		N/A
Inspections Completed	141	126	151		418
PRP Referrals to Treatment					
Referrals to Treatment	2	4	3		9
Drug Tests					
Drug Test Ordered	911	908	971		2790
Drug Tests Conducted	895	898	962		2755
Relapse					
Relapsed	1	3			4
Major Violation Actions					
Cease Practice/Suspension	4	8	7		19
Termination - PRP	2		2		4
Referral for Discipline					
Exit from PRP or Probation					
Successful Completion	4	2	4		10
Termination - Probation	1				1
Voluntary Surrender	3	4	5		12
Surrender as a result of PTR	1	1			2
Public Risk	2		2		4
Non-compliance	19	7	18		44
Other			2		2
Patients Harmed					
Number of Patients Harmed	None	None	None	None	None

SB 1441 – Program Statistics

Licensees with substance abuse problems who are either on board probation and/or participating in the Pharmacist Recovery Program (PRP)

Board of Pharmacy	July -Sep	Oct – Dec	Jan-Mar	Apr-Jun	Total 16/17
Drug of Choice at PRP Intake or Probation					
Pharmacists	**July-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Total 16/17**
Alcohol	1	2	3		6
Ambien					
Opiates	3				3
Hydrocodone	1	2			3
Oxycodone	1				1
Morphine					
Benzodiazepines					
Barbiturates					
Marijuana		1			1
Heroin					
Cocaine					
Methamphetamine					
Pharmaceutical Amphetamine					
Phentermine					
Methadone					
Zolpidem Tartrate					
Hydromorphone					
Clonazepam					
Tramadol		1			1
Carisprodol					
Phendimetrazine					
Promethazine w/Codeine					
Intern Pharmacists	**July-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Total 16/17**
Alcohol		2			2
Opiates					
Hydrocodone					
Oxycodone					
Benzodiazepines					
Barbiturates					
Marijuana					
Heroin					
Cocaine					
Methamphetamine					
Pharmaceutical Amphetamine					
Phentermine					
Methadone					
Zolpidem Tartrate					
Hydromorphone					
Clonazepam					
Tramadol					
Carisprodol					
Phendimetrazine					
Promethazine w/Codeine					
Pharmacy Technicians	**July-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Total 16/17**
Alcohol	1	2	4		7
Opiates					
Hydrocodone					
Oxycodone					
Benzodiazepines	1				1
Barbiturates					
Marijuana	2	1			3
Heroin		1			1
Cocaine					
Methamphetamine	1		1		2
Pharmaceutical Amphetamine					
Phentermine					
Methadone					
Zolpidem Tartrate					
Hydromorphone					
Clonazepam					
Tramadol					
Carisprodol					
Phendimetrazine					
Promethazine w/Codeine					

Drug Of Choice - Data entered from July 2016 to June 2017



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California State Board of Pharmacy
Citation and Fine Statistics January
January 1, 2017 - March 31, 2017

536 Citations Were Issued This Quarter

Total dollar amount of fines issued this fiscal year $504,300.00

***This amount also reflects payment of citations issued prior to July 1, 2009.**

The average number of days from date case is opened until a citation is issued is 209.53

Average number of days from date case is routed to Citation Unit to date citation is issued 29.36

471 citations are closed. The average number of days from date citation is issued to date citation is closed is 147.46

Citation Breakdown by license type

Total issued	RPH with fine	RPH no fine	PHY with fine	PHY no fine	PIC with fine**	PIC no fine**	TCH with fine	TCH no fine
536	235	21	85	90	93	48	50	0

Citation Breakdown by Miscellaneous license type

Wholesalers	Exemptee's	Clinics	Drug Room	Exempt Hosp.	Hosp. Pharmacy	Misc.*	Unlicensed Premises	Unlicensed person
2	0	1	0	4	9	26	12	1

*Intern Pharmacist, Licensed Correctional Facilities, Exempt Pharmacies, Non-Resident Pharmacies, and Vet Retailers

**These numbers are also represented in the RPH columns, but reflect how many RPHs were cited as PICs

Top Ten Violations by license type

Pharmacists	%	Pharmacies	%	Pharmacists In Charge	%
1716 - Variation from prescription	18%	1716 - Variation from prescription	24%	1714(d) - Operational Standards and Security; Pharmacist responsible for pharmacy security	34%
4301(g) - Unprofessional Conduct - Knowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a state of facts	17%	1714(b) - Operational Standards and Security; pharmacy responsible for pharmacy security	16%	1761(a) - No pharmacist shall compound or dispense any prescription, which contains any significant error or omission…	12%
1761(a) - No pharmacist shall compound or dispense any prescription, which contains any significant error or omission…	15%	4113(d) - Every pharmacy shall notify the board in writing within 30 days of the date of a change in pharmacist-in-charge	14%	11165(d)(2) - Pharmacy shall provide the following information the Department of Justice: prescriber's category of licensure and license number; federal controlled substance registration number ...	11%
4231(d)/1732.5 - Failure to provide documentation substantiating completion of continuing education/Renewal Requirements for Pharmacist	14%	1761(a) - No pharmacist shall compound or dispense any prescription, which contains any significant error or omission…	12%	1716 - Variation from prescription	9%
1714(d) - Operational Standards and Security; Pharmacist responsible for pharmacy security	11%	11164(a)/1761(a) - Prescriptions for schedule II, III, IV, and controlled substance: form and content; record of practitioner dispensing schedule II controlled substance/No pharmacist shall compound o	9%	11164(a)/1761(a) - Prescriptions for schedule II, III, IV, and controlled substance: form and content; record of practitioner dispensing schedule II controlled substance/No pharmacist shall compound o	8%
11164(a)/1761(a) - Prescriptions for schedule II, III, IV, and controlled substance: form and content; record of practitioner dispensing schedule II controlled substance/No pharmacist shall compound o	9%	4305(b) - Disciplinary Grounds: Failure of Pharmacy or Pharmacist to Notify Board of Termination of Pharmacist-in-Charge; Continuing to Operate Without Pharmacist; Operation of a pharmacy for more tha	6%	1735.2(h) - Every compounded drug product shall be given an expiration date...	7%
1761(a)&(b) - No pharmacist shall compound or dispense any prescription, which contains any significant error or omission…/A pharmacist shall not compound or dispense a prescription for a controlled s	4%	4113(a) - Pharmacist-in-Charge: Notification to Board; Responsibilities; Every pharmacy shall designate a pharmacist-in-charge within 30 days in writing of the identity and license number of that phar	6%	4076(a)(4) - Prescription Container - Requirements for Labeling/The name of the prescriber…	6%
11164(a) - Prescriptions for schedule II, III, IV, and controlled substance: form and content; record of practitioner dispensing schedule II controlled substance	4%	4076(a)(4) - Prescription Container - Requirements for Labeling/The name of the prescriber…	5%	4081(a) - Records of Dangerous Drugs and Devices Kept Open for Inspection; Maintenance of Records, Current Inventory	4%
4076(a)(4)/1707.1(a)(1)(B)(2) - Prescription Container - Requirements for Labeling/The name of the prescriber…/Duty to maintain medication profiles; a patient medication profile shall be maintained… f	4%	4081(a)/4105(a)(b)(c) - Records of Dangerous Drugs and Devices Kept Open for Inspection; Maintenance of Records, Current Inventory/Retaining Records of Dangerous Drugs and Devices on Licensed Premises	4%	1761 - Erroneous or uncertain prescriptions	4%
11164 - Prescribing, Filling, Compounding or Dispensing Prescription for Controlled Substance; Requirements	4%	11165(d)(2) - Pharmacy shall provide the following information the Department of Justice: prescriber's category of licensure and license number; federal controlled substance registration number ...	4%	4127.1(a) - A pharmacy shall not compound injectable sterile drug products…unless the pharmacy has obtained a license from the board.	4%