



DISCIPLINARY ACTIVITY: July 2018

The Board took the following disciplinary actions involving **pharmacists** at its July, 2018 meeting:

Gaasch, Clarissa Y., License # 115936. Licensee has an intermittent history of alcohol abuse, with a relapse beginning in September of 2017. On several occasions, licensee reported to work either under the influence of alcohol or hungover. On April 28, 2018, after consuming a pint of liquor and some wine, she was involved in a motor vehicle accident and was subsequently charged with driving under the influence. Consequently, the Board adopted a Stipulation and Consent Order, indefinitely suspending her license to practice pharmacy.

The Board took the following disciplinary actions involving **pharmacies** at its July, 2018 meeting:

GenRx, License # 265062. Between January 19, 2015 and May 12, 2016, Licensee dispensed and shipped one hundred and twenty-one prescriptions to Minnesota patients, prior to being licensed by the Board. The CEO of the Licensee stated that a number of policies and computer fail-safe settings had been implemented to prevent this activity for states in which the pharmacy is not licensed. In addition, Licensee has been

disciplined by the Boards of Pharmacy for Alabama, Oregon, Kentucky, California, and South Carolina. Consequently, the Board issued a Stipulation and Consent Order, reprimanding the licensee and assessing a civil penalty in the amount of \$2,500.

MasterPharm, LLC, License # 263178. Between 2008 and 2016, Licensee was disciplined by the applicable licensing boards in the states of Missouri, Colorado, Nebraska, New York, Iowa, Ohio, California, Michigan, Louisiana, Wisconsin, Alabama, Indiana, Texas and New Hampshire. In November 2015, Licensee submitted a response to the Board that contained various mischaracterizations regarding some of these disciplinary actions. Between 2014 and 2017, the U.S. Food and Drug Administration, and the National Association of Boards of Pharmacy, conducted inspections of Licensee's facilities, during which inspectors observed noncompliance with select provisions of USP Chapter 797 standards for sterile compounding. Licensee represents it has taken appropriate corrective actions in response to these observations. On or about January 8, 2016, the FDA issued a Warning Letter to Licensee in follow-up to its inspections, noting that Licensee's drug products intended or expected to be sterile were prepared, packed or held under insanitary conditions, citing several examples. The Warning Letter acknowledged receipt of Licensee's response to a Form 483 and noted that several of Licensee's proposed corrective actions appeared adequate but that others were deficient. On or about July 7, 2017, the FDA issued a Close Out Letter to Licensee, noting Licensee's corrective actions taken in response to the Warning Letter and concluded that it appeared that Licensee had adequately addressed the violations contained in the Warning Letter. From approximately 2008 to 2010, Licensee compounded and dispensed into Minnesota 75 mg Testosterone Pellets pursuant to

patient-specific prescriptions issued by practitioners. In or around 2010, Licensee advised a number of bio-identical hormone replacement therapy clinics located in Minnesota that it would no longer offer 75 mg Testosterone Pellets and would instead begin offering 70 mg Testosterone Pellets. Prescribers at these clinics adjusted their prescribing practices to utilize Licensee's compounded 70 mg Testosterone Pellets. From approximately August 15, 2008 to the date of this Stipulation, Licensee compounded and dispensed into Minnesota a combination of 25 mg and 50 mg Testosterone Pellets for patients who needed a 75 mg Testosterone Pellet. Consequently, the Board issued a Stipulation and Consent Order, reprimanding the Licensee, imposing a civil penalty of \$50,000, and requiring the Licensee to: within 120 days, submit to the Board a copy of list of all compounded drugs compounded and shipped into Minnesota, followed biannually by submission of an updated list, for a period of five years; and submit a National Association of Boards of Pharmacy (NABP) Verified Pharmacy Program Inspection (VPP) report annually for the period of five years.

The Board took the following disciplinary actions involving pharmacy technicians at its July, 2018 meeting:

Hayat, Hina Fayyaz, Registration # 734736. On April 12, 2017, the Board sent Registrant a letter requesting submission of the following documentation as required for registration: Registrant's high school diploma or general education development ("GED") certificate; and Registrant's certificate of completion of a formal pharmacy technician training course, completed within twelve months of initial registration. The Board subsequently sent other requests to the Registrant, again requesting the

documentation. The Registrant has failed to provide the required documentation in response to any requests made by the Board. The Registrant further failed to respond to notifications concerning the disciplinary case that the Board opened in this matter. Consequently, the Board issued Findings of Fact, Conclusions, and Final Order, revoking Registrant's registration.

Jacobs, Dawn Marie, Registration # 706993. On March 13, 2017, in Stearns County District Court, Minnesota, Registrant was criminally charged with 3rd Degree DWI – 0.08 Within Two Hours, and 4th Degree DWI (Case No. 73-CR-17-6200). On or about April 10, 2017, Registrant was referred by a third party to the Health Professionals Services Program (“HPSP”), due to Registrant's previously diagnosed alcohol use disorder - severe, and her ongoing use of alcohol. On April 16, 2017, in Stearns County District Court, Minnesota, Registrant was criminally charged with 3rd Degree DWI – Test Refusal, and 4th Degree DWI (Case No. 73-CR-17-6695). On May 1, 2017, Registrant entered into a participation agreement with the HPSP. Thereafter, Registrant failed to comply with the terms and conditions of her HPSP participation agreement. Specifically, Registrant did not follow treatment recommendations to attend outpatient treatment or mental health therapy. Registrant also failed to provide random toxicology screens as required. As a result, on July 20, 2017, Registrant was unsatisfactorily discharged from the HPSP. On January 11, 2018, an Apprehension & Detention Order was issued for Registrant by the Sartell, Minnesota Police Department, on a suspected parole violation involving the use of alcohol. On that date and time, Registrant was scheduled to work her shift as a pharmacy technician at a retail pharmacy located in Sartell, Minnesota. Before entering the pharmacy, Registrant consumed alcohol. Sartell

law enforcement officers located Registrant at the pharmacy, and smelled the odor of alcohol on her breath. Registrant was transported back to the Sartell Police Department, where an Intake Preliminary Breath Test (PBT) was administered. The result showed Registrant had a Blood Alcohol Content of 0.086 percent. Thereafter, Registrant resigned from her position as a pharmacy technician. On February 2, 2018, Registrant pled guilty to the March 13, 2017 3rd Degree DWI, and the April 16, 2017 3rd Degree DWI – Test Refusal. Consequently, the Board issued a Stipulation and Consent Order, suspending Registrants pharmacy technician registration, but staying the suspension on condition that Registrant enrolls in and successfully completes the Health Professionals Services Program.

Jensen, Cole E., Registration # 732365. Previously, registrant had allowed his pharmacy technician registration to expire on December 31, 2013 and did not renew his registration until 16 months later, on April 29, 2015. He again allowed his registration to expire on December 31, 2015. Registrant worked at least one and possibly more shifts as a pharmacy technician without being registered to do so, during January and February, 2016. Registrant has not completed a required pharmacy technician training program. Consequently, the Board issued a Stipulation and Consent Order in April of 2017, reprimanding registrant, imposing a civil penalty of \$250 and conditioning his continued registrant on completion of a technician training program by July 1, 2018.

Registrant satisfactorily completed the requirements of his order. Consequently, the Board issued an Order of Reinstatement of Registration.

Sanchez, Tessaca Lynn, Registration # 739167. On April 17, 2018, Registrant admitted to managers of the pharmacy at which she worked that she diverted

approximately 70 tablets of multiple strengths of hydrocodone/acetaminophen containing products from the pharmacy, for her personal consumption. Consequently, the Board accepted the voluntary surrender of her registration and issued a Stipulation and Consent Order for Voluntary Surrender.