BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Thor-Alcyone Lopez Reyes, M.D.** **Physician's and Surgeon's Certificate No. C 38408** **Respondent.**	**Case No. 800-2017-038136**

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on OCT 0 1 2020.

IT IS SO ORDERED SEP 2 4 2020.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
EDWARD KIM
Deputy Attorney General
State Bar No. 195729
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6000
Facsimile: (916) 731-2117
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **THOR-ALCYONE LOPEZ REYES, M.D.** **Physician's and Surgeon's Certificate No. C 38408,** Respondent.	Case No. 800-2017-038136 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Edward Kim, Deputy Attorney General.

2. THOR-ALCYONE LOPEZ REYES, M.D. (Respondent) is represented in this proceeding by attorney Carlo Reyes, whose address is: 893 Patriot Dr., Unit A, Moorpark CA 93021-3357.

3. On or about November 29, 1978, the Board issued Physician's and Surgeon's Certificate No. C 38408 to THOR-ALCYONE LOPEZ REYES, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the

charges brought in Accusation No. 800-2017-038136 and will expire on November 30, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-038136 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 10, 2020. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2017-038136 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-038136. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2017-038136, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline.

Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C 38408, issued to Respondent THOR-ALCYONE LOPEZ REYES, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. The effective date of the Board's Decision and Order shall be October 1, 2020 (Effective Date). Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of Effective Date.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement with the Board in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2017-038136 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2017-038136 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Carlo M. Reyes. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: Aug 7, 2020 Thor-Alcyone Lopez Reyes MD

THOR-ALCYONE LOPEZ REYES, M.D.
Respondent

I have read and fully discussed with Respondent THOR-ALCYONE LOPEZ REYES, M.D.

the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 8/2/20

CARLO M. REYES
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: _____

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

EDWARD KIM
Deputy Attorney General
Attorneys for Complainant

LA2020500569
63444701.docx

the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: _____ _____
CARLO M. REYES
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 8-18-20

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

EDWARD KIM
Deputy Attorney General
Attorneys for Complainant

LA2020500569
63444701.docx

Exhibit A

Accusation No. 800-2017-038136

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
EDWARD KIM
Deputy Attorney General
State Bar No. 195729
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6000
Facsimile: (916) 731-2117
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **THOR-ALCYONE LOPEZ REYES, M.D.** **893 Patriot Drive, Bldg. J, Unit A** **Moorpark, CA 93021** **Physician's and Surgeon's** **Certificate No. C 38408,** Respondent.	Case No. 800-2017-038136 **A C C U S A T I O N**

PARTIES

1. Christine J. Lally (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about November 29, 1978, the Board issued Physician's and Surgeon's Certificate Number C 38408 to THOR-ALCYONE LOPEZ REYES, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2020, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2238 of the Code states:

> A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

7. Section 2241 of the Code states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

(d)(1) For purposes of this section and Section 2241.5, addict means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

8. Section 2241.5 of the Code states:

(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the

following:

(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

(2) Violates Section 2241 regarding treatment of an addict.

(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.

(4) Violates Section 2242.1 regarding prescribing on the Internet.

(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5.

9. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

10. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

11. Health and Safety Code § 11165 states:

(a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The Department of Justice may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations.

(2) (A) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil,

or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, if patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party, unless authorized by, or pursuant to, state and federal privacy and security laws and regulations. The Department of Justice shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

(B) Notwithstanding subparagraph (A), a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances shall not be provided data obtained from CURES.

(3) The Department of Justice shall, no later than July 1, 2020, adopt regulations regarding the access and use of the information within CURES. The Department of Justice shall consult with all stakeholders identified by the department during the rulemaking process. The regulations shall, at a minimum, address all of the following in a manner consistent with this chapter:

(A) The process for approving, denying, and disapproving individuals or entities seeking access to information in CURES.

(B) The purposes for which a health care practitioner may access information in CURES.

(C) The conditions under which a warrant, subpoena, or court order is required for a law enforcement agency to obtain information from CURES as part of a criminal investigation.

(D) The process by which information in CURES may be provided for educational, peer review, statistical, or research purposes.

(4) In accordance with federal and state privacy laws and regulations, a health care practitioner may provide a patient with a copy of the patient's CURES patient activity report as long as no additional CURES data is provided and keep a copy of the report in the patient's medical record in compliance with subdivision (d) of Section 11165.1.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed, in a format specified by the Department of Justice:

(1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider

identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility, if provided.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(11) The serial number for the corresponding prescription form, if applicable.

(e) The Department of Justice may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. All prescriber and dispenser invitees shall be licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

(f) The Department of Justice shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, one or more of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, and any other stakeholder identified by the department, for the purpose of identifying desirable capabilities and upgrades to the CURES Prescription Drug Monitoring Program (PDMP).

(g) The Department of Justice may establish a process to educate authorized subscribers of the CURES PDMP on how to access and use the CURES PDMP.

(h) (1) The Department of Justice may enter into an agreement with any entity operating an interstate data sharing hub, or any agency operating a prescription drug monitoring program in another state, for purposes of interstate data sharing of prescription drug monitoring program information.

(2) Data obtained from CURES may be provided to authorized users of another state's prescription drug monitoring program, as determined by the Department of Justice pursuant to subdivision (c), if the entity operating the interstate data sharing hub, and the prescription drug monitoring program of that state, as applicable, have entered into an agreement with the Department of Justice for interstate data sharing of prescription drug monitoring program information.

(3) Any agreement entered into by the Department of Justice for purposes of interstate data sharing of prescription drug monitoring program information shall ensure that all access to data obtained from CURES and the handling of data contained within CURES comply with California law, including regulations, and meet the same patient privacy, audit, and data security standards employed and required for direct access to CURES.

(4) or purposes of interstate data sharing of CURES information pursuant to this subdivision, an authorized user of another state's prescription drug monitoring program shall not be required to register with CURES, if the authorized user is registered and in good standing with that state's prescription drug monitoring program.

(5) The Department of Justice shall not enter into an agreement pursuant to this subdivision until the department has issued final regulations regarding the access and use of the information within CURES as required by paragraph (3) of subdivision (c).

(i) This section shall remain in effect only until January 1, 2021, and as of that date is repealed.

12. Health and Safety Code § 11165.1 states:

(a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the Department of Justice. Upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under the practitioner's care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before July 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the Department of Justice. Upon approval, the department shall release to that pharmacist the electronic history of controlled substances dispensed to an individual under the practitioner's care based on data contained in the CURES PDMP.

(B) An application may be denied, or a subscriber may be suspended, for reasons which include, but are not limited to, the following:

(i) Materially falsifying an application to access information contained in the CURES database.

(ii) Failing to maintain effective controls for access to the patient activity report.

(iii) Having his or her federal DEA registration suspended or revoked.

(iv) Violating a law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

(v) Accessing information for a reason other than to diagnose or treat a patient,

or to document compliance with the law.

(C) An authorized subscriber shall notify the Department of Justice within 30 days of any changes to the subscriber account.

(D) Commencing no later than October 1, 2018, an approved health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist pursuant to subdivision (b) of Section 209 of the Business and Professions Code may use the department's online portal or a health information technology system that meets the criteria required in subparagraph (E) to access information in the CURES database pursuant to this section. A subscriber who uses a health information technology system that meets the criteria required in subparagraph (E) to access the CURES database may submit automated queries to the CURES database that are triggered by predetermined criteria.

(E) Commencing no later than October 1, 2018, an approved health care practitioner or pharmacist may submit queries to the CURES database through a health information technology system if the entity that operates the health information technology system can certify all of the following:

(i) The entity will not use or disclose data received from the CURES database for any purpose other than delivering the data to an approved health care practitioner or pharmacist or performing data processing activities that may be necessary to enable the delivery unless authorized by, and pursuant to, state and federal privacy and security laws and regulations.

(ii) The health information technology system will authenticate the identity of an authorized health care practitioner or pharmacist initiating queries to the CURES database and, at the time of the query to the CURES database, the health information technology system submits the following data regarding the query to CURES:

(I) The date of the query.

(II) The time of the query.

(III) The first and last name of the patient queried.

(IV) The date of birth of the patient queried.

(V) The identification of the CURES user for whom the system is making the query.

(iii) The health information technology system meets applicable patient privacy and information security requirements of state and federal law.

(iv) The entity has entered into a memorandum of understanding with the department that solely addresses the technical specifications of the health information technology system to ensure the security of the data in the CURES database and the secure transfer of data from the CURES database. The technical specification shall be universal for all health information technology systems that establish a method of system integration to retrieve information from the CURES database. The memorandum of understanding shall not govern, or in any way impact or restrict, the use of data received from the CURES database or impose any additional burdens on covered entities in compliance with regulations promulgated pursuant to the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations.

(F) No later than October 1, 2018, the department shall develop a programming interface or other method of system integration to allow health information technology systems that meet the requirements in subparagraph (E) to retrieve information in the CURES database on behalf of an authorized health care practitioner or pharmacist.

(G) The department shall not access patient-identifiable information in an entity's health information technology system.

(H) An entity that operates a health information technology system that is requesting to establish an integration with the CURES database shall pay a reasonable fee to cover the costs of establishing and maintaining integration with the CURES database.

(I) The department may prohibit integration or terminate a health information technology system's ability to retrieve information in the CURES database if the health information technology system fails to meet the requirements of subparagraph (E), or the entity operating the health information technology system does not fulfill its obligation under subparagraph (H).

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

(b) A request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the Department of Justice.

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section is medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

(f) A health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising from any false, incomplete, inaccurate, or misattributed information submitted to, reported by, or relied upon in the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

(g) For purposes of this sections, the following terms have the following

meanings:

(1) "Automated basis" means using predefined criteria to trigger an automated query to the CURES database, which can be attributed to a specific health care practitioner or pharmacist.

(2) "Department" means the Department of Justice.

(3) "Entity" means an organization that operates, or provides or makes available, a health information technology system to health care practitioner or pharmacist.

(4) "Health information technology system" means an information processing application using hardware and software for the storage, retrieval, sharing of or use of patient data for communication, decisionmaking, coordination of care, or the quality, safety, or efficiency of the practice of medicine or delivery of health care services, including, but not limited to, electronic medical record applications, health information exchange systems, or other interoperable clinical or health care information system.

(5) "User initiated basis" means an authorized health care practitioner or pharmacist has taken an action to initiate the query to the CURES database, such as clicking a button, issuing a voice command, or taking some other action that can be attributed to a specific health care practitioner or pharmacist.

(h) This section shall become inoperative on July 1, 2021, or upon the date the department promulgates regulations to implement this section and posts those regulations on its internet website, whichever date is earlier, and, as of January 1, 2022, is repealed.

13. Health and Safety Code § 11165.4 states:

(a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time the health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient, the health care practitioner shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(B) For purposes of this paragraph, "first time" means the initial occurrence in which a health care practitioner, in their role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance

history from the CURES database no earlier than 24 hours, or the previous business day, before the health care practitioner prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in

Section 1339.40.

(5) (A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason they did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within the health care practitioner's control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

(d) (1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or

applications that can be given effect without the invalid provision or application.

(h) This section shall become inoperative on July 1, 2021, or upon the date the department promulgates regulations to implement this section and posts those regulations on its internet website, whichever date is earlier, and, as of January 1, 2022, is repealed.

14. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

15. Section 829, subdivision (a) of Title 21 of the United States Code states, in pertinent part:

. . . No prescription for a controlled substance in schedule II may be refilled.

16. Section 1306.05, subdivision (a) of Title 21 of the Code of Federal Regulations states:

Manner of issuance of prescriptions. (a) All prescriptions for controlled substances shall be dated as of, and signed on, the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use, and the name, address and registration number of the practitioner.

DEFINITIONS

17. As used herein, the terms below will have the following meanings:

"Abilify®": see aripiprazole, below.

"ADD" means attention deficit disorder.

"Adderall®" is a brand name of a combination of two stimulant drugs, amphetamine and dextroamphetamine. It is generally used to treat attention deficit

hyperactivity disorder, but also has a high potential for abuse. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(1), and a dangerous drug as defined in Business and Professions Code section 4022.

"Alprazolam" is a benzodiazepine drug used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Alprazolam has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other central nervous system depressant drugs during treatment with it. Addiction prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to habituation and dependence. The usual starting dose of alprazolam is 0.25 mg to 0.5 mg, three times per day (for a maximum 1.5 mg per day). It is also sold under various brand names including, Intensol®, Xanax®, and Xanax XR®. It is a schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(1), and a dangerous drug as defined in Business and Professions code section 4022. It is also a Schedule IV controlled substance as defined by the Code of Federal Regulations Title 21, section 1308.14 (c).

"Amitriptyline" is a drug primarily used to treat a number of mental illnesses, including major depressive disorder and anxiety disorders, and less commonly attention deficit hyperactivity disorder (ADHD) and bipolar disorder. Other uses include prevention of migraines and the treatment of neuropathic pain. It is sold under the brand name, Elavil®, among others. It is a dangerous drug as defined in Business and Professions code section 4022.

"AndroGel®" is a brand name for a testosterone gel medication which is a naturally occurring steroid hormone. It is used to treat male hypogonadism and certain types of breast cancer. Testosterone can be used as a gel or patch that is applied to the skin, injection into a muscle, tablet that is placed in the cheek, or tablet that is taken by mouth. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11056, subdivision (f)(30), and a dangerous drug as defined in Business and Professions Code section 4022.

"Aripiprazole" is an atypical antipsychotic medication. It is primarily used in the treatment of schizophrenia and bipolar disorder. Other uses include as an add-on treatment in major depressive disorder, tic disorders and irritability associated with autism. It is sold under the brand name Abilify®, among others. It is a dangerous drug as defined in Business and Professions code section 4022.

"Ativan®": see lorazepam, below.

"Benadryl®": see diphenhydramine, below.

"Benzodiazepines" are a class of drugs that produce central nervous system (CNS) depression. They are used therapeutically to produce sedation, induce sleep, relieve anxiety and muscle spasms, and to prevent seizures. They are most commonly used to treat insomnia and anxiety. In general, benzodiazepines act as hypnotics in high doses, anxiolytics in moderate doses, and sedatives in low doses. There is the potential for dependence on and abuse of benzodiazepines particularly by individuals with a history of multi-substance abuse. Benzodiazepines can cause dangerous deep unconsciousness. When combined with other CNS depressants such as alcoholic drinks and opioids, the potential for toxicity and fatal overdose increases. Benzodiazepines are commonly misused and taken in combination with other drugs of abuse. Alprazolam (Xanax®), lorazepam (Ativan®), clonazepam

(Klonopin®), diazepam (Valium®), and temazepam (Restoril®) are among the most prescribed, as well as the most frequently encountered benzodiazepines on the illicit market. Benzodiazepines are generally used for a limited time period and daily use should only be attempted after other approaches are unsuccessful, and with continuing attention to tapering and discontinuance. Prescribed benzodiazepines should be discussed with the patient (and those patient interactions should be documented), including that they entail: 1) risk of tolerance and dependence, 2) potential interactions with alcohol and pain medications, and 3) possible impairment of driving.

"Bupropion" is an antidepressant medication used to treat major depression and to assist with smoking cessation. It is also sold under various brand names including, Wellbutrin®, Zyban®, Voxra® and Budeprion®, among others. It is a dangerous drug as defined in Business and Professions Code section 4022.

"Clonazepam" is a benzodiazepine-based sedative. It is generally used to control seizures and panic disorder. It is sold under the brand name Klonopin®. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7), and a dangerous drug as defined in Business and Professions Code section 4022.

"Chlorpromazine" is an antipsychotic medication. It is primarily used to treat psychotic disorders such as schizophrenia or manic-depression in adults. It is also used to treat bipolar disorder, severe behavioral problems in children including those with attention deficit hyperactivity disorder, nausea and vomiting, anxiety before surgery, and hiccups. It is sold under the brand names Thorazine® and Largactil®, among others. It is a dangerous drug as defined in Business and Professions Code section 4022.

"CURES" means the Department of Justice, Bureau of Narcotics Enforcement's California Utilization, Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, III and IV controlled substances dispensed to patients in California pursuant to Health and Safety Code section 11165. The CURES database captures data from all Schedule II, III and IV controlled substance prescriptions filled as submitted by pharmacies, hospitals, and dispensing physicians. Law enforcement and regulatory agencies use the data to assist in their efforts to control the diversion and resultant abuse of Schedule II, III and IV drugs. Prescribers and pharmacists may request a patient's history of controlled substances dispensed in accordance with guidelines developed by the Department of Justice.

"Diazepam" is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It can produce psychological and physical dependence and should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence. It is sold under the brand name Valium®. It is a schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(1), and is a dangerous drug as designated in Health and Safety Code section 4022.

"Diphenhydramine" is an antihistamine used to treat symptoms of seasonal allergies including sneezing, runny nose, and itching or watering eyes. It works by blocking the action of histamine which causes allergic symptoms. It is available over-the-counter, and also sold under the brand name Benadryl®.

"Divalproex sodium" is an anticonvulsant mood stabilizer drug that can be

used to treat bipolar disorder and seizures. It can also help prevent migraine headaches. It is sold under the brand name of Depakote® which is a prescription drug (generic name valproic acid). It is a dangerous drug as defined in Business and Professions Code section 4022.

"Doxepin" is a tricyclic antidepressant that affects chemicals in the brain that may be unbalanced. Doxepin (Sinequan or other generic name) is used to treat symptoms of depression and/or anxiety associated with alcoholism, psychiatric conditions, or manic-depressive conditions. It is sold under the brand names of Silenor®, Prudoxin®, and Zonalon®. It is a dangerous drug as defined in Business and Professions Code section 4022.

"Elavil®": see amitriptyline, above.

"Escitalopram" is included in the class of drugs called selective serotonin reuptake inhibitors (SSRIs). This class of drugs is used to treat depression, anxiety, and other mood disorders. Escitalopram is mainly used to treat major depressive disorder or generalized anxiety disorder. It is sold under the brand names, Cipralex® and Lexapro®, among others. It is a dangerous drug as defined in Business and Professions code section 4022.

"Gabapentin" is an anticonvulsant medication used to treat partial seizures, neuropathic pain, hot flashes, and restless legs syndrome. It is recommended as one of a number of first-line medications for the treatment of neuropathic pain caused by diabetic neuropathy, postherpetic neuralgia, and central neuropathic pain. It is sold under the brand name Neurontin® among others. It is a dangerous drug as defined in Business and Professions Code section 4022.

"GAF" means the Global Assessment of Functioning scoring system that mental health professionals use to assess how well an individual is functioning in their daily lives.

"Including" means including, without limitation.

"Klonopin®": see clonazepam, above.

"Latuda®": see lurasidone, below.

"Levothyroxine" is a hormone used to treat hypothyroidism (condition where the thyroid gland does not produce enough thyroid hormone).

"Lexapro®": see escitalopram, above.

"Lisdexamfetamine" is a stimulant used as part of a treatment program to control symptoms of attention deficit hyperactivity disorder (ADHD; more difficulty focusing, controlling actions, and remaining still or quiet than other people who are the same age) in adults and children. It is a psychostimulant prodrug of the phenethylamine and amphetamine chemical classes. It is sold under the brand name Vyvanse®. It is a dangerous drug as defined in Business and Professions Code section 4022.

"Lorazepam" is a benzodiazepine medication. It is used to treat anxiety disorders, trouble sleeping, active seizures including status epilepticus, alcohol withdrawal, and chemotherapy induced nausea and vomiting, as well as for surgery to interfere with memory formation and to sedate those who are being mechanically ventilated. It is sold under the brand name Ativan® among others. It is a Schedule

IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug pursuant to Business and Professions Code section 4022.

"Lurasidone" is an antipsychotic medication used to treat schizophrenia and bipolar disorder. It is sold under the trade name Latuda® among others. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Mirtazapine" is an antidepressant primarily used to treat depression. It is often used to treat depression complicated by anxiety or trouble sleeping. It is sold under the trade name Remeron® among others. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Neurontin®": see gabapentin, above.

"Oxazepam" is a short-to-intermediate-acting benzodiazepine. It is used to treat anxiety and insomnia and in the control of symptoms of alcohol withdrawal syndrome. It is sold under the brand name Serax®. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(23), and a dangerous drug as defined in Business and Professions Code section 4022.

"Phentermine" is a stimulant similar to an amphetamine. It acts as an appetite suppressant by affecting the central nervous system. It is used medically as an appetite suppressant for short term use, as an adjunct to exercise and reducing calorie intake. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (b)(f)(4), and a dangerous drug pursuant to Business and Professions Code section 4022.

"Quetiapine" is an atypical antipsychotic drug used for the treatment of schizophrenia, bipolar disorder, and major depressive disorder. It is sold under the brand name Seroquel®, among others. It is a dangerous drug pursuant to Business and Professions code section 4022.

"Serax®": see oxazepam, above.

"Seroquel®": see quetiapine, above.

"SSRI" means Selective Serotonin Reuptake Inhibitor. SSRI antidepressants are a type of antidepressant that work by increasing levels of serotonin within the brain. Serotonin is a neurotransmitter that is often referred to as the "feel good hormone."

"Temazepam" is a benzodiazepine medication. It is generally indicated for the short-term treatment of insomnia. It is sold under the brand names Restoril® among others. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(29), and a dangerous drug as defined in Business and Professions Code section 4022.

"Thorazine®": see chlorpromazine, above.

"Trazodone" is an antidepressant medication. It is used to treat major depressive disorder, anxiety disorders, and in addition to other treatment, alcohol dependence. It is dangerous drug as defined in Business and Professions code section 4022.

"Valium®": see diazepam, above.

"Venlafaxine" is an antidepressant belonging to a group of drugs called selective serotonin and norepinephrine reuptake inhibitors (SSNRIs). Venlafaxine affects chemicals in the brain that may be unbalanced in people with depression. Venlafaxine is used to treat major depressive disorder, anxiety and panic disorder. If is sold under various brand names, including, Effexor XR®. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Vyvanse®": see lisdexamfetamine, above.

"Wellbutrin®": see bupropion, above.

"Xanax®": see alprazolam, above.

"Ziprasidone" is an atypical antipsychotic medication used to treat schizophrenia and bipolar disorder. It is sold under the brand name Geodon® among others. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Zolpidem" is a sedative primarily used for the treatment of trouble sleeping. It has a short half-life. Its hypnotic effects are similar to those of the benzodiazepine class of drugs. It is sold under the brand name Ambien®. It is a schedule IV controlled substance and narcotic as defined by Health and Safety Code section 11057, subdivision (d)(32) and a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS: Patients A and B

Subject Interview

18. On or about March 21, 2019, a Department of Consumer Affairs, Division of Investigation, Health Quality Investigations Unit ("HQIU") investigator and a medical consultant, on behalf of the Board, interviewed ("Subject Interview") Respondent. During his Subject Interview, Respondent stated that he performed his residency in psychiatry. He also admitted that he was not registered with CURES and was not familiar with the program. The investigator informed Respondent that he was required by law to sign up with CURES.

Patient A[1]

19. On or about April 13, 2016, Respondent first saw Patient A,[2] a 63-year-old woman with a history of psychiatric treatment. She was employed and her family history included an alcoholic father and an uncle with drug addiction. She had never taken psychiatric medications before. She had been to jail and suffered two driving under the influence events. Respondent diagnosed Patient A with anxiety disorder NOS with depressive episodes. He prescribed

[1] The patients are designated by letters to address privacy concerns. The identity of the patients are known to Respondent.

[2] Her partner, Patient B, was also a patient of Respondent.

Ativan® (1 mg at bedtime with two refills – 90 tablets) to Patient A. At the top of the first page of his initial psychiatric consultation note, there were three numbers written in handwriting that Respondent did not know how to interpret. There were portions of the preprinted form that were not completed by Respondent, including an entire page with preprinted questions about "Alcohol or substance abuse." At his Subject Interview, Respondent stated that the history at this first visit was "very limited." There were other forms in Respondent's records signed by Patient A on varying dates. A patient HIPPA consent form was signed by Patient A on April 15, 2016. An insurance verification form was signed by Patient A and dated April 28, 2016. However, Respondent could not explain these different dates.

20. Respondent's next documented visit with Patient A was on or about May 3, 2016. Respondent discussed her medications with her and the transfer of the prescriptions from her primary care doctor to himself. No risk factors were noted at that time. No abuse of alcohol or street drugs were noted. His plan was to "continue meds."

21. On or about May 19, 2016, an Express Scripts pharmacy record indicated that Respondent prescribed escitalopram (0.10 mg) to Patient A. There was no office visit with Respondent corresponding to this prescription. At his Subject Interview, Respondent explained that, "sometimes, I am not really able to write . . . because they call me, let's say at home, and I call the pharmacy . . . and I neglect to -- to uh -- write all of these things." He added that, "there are prescriptions that I call in to the pharmacy -- uh -- that may not readily appear in their record."

22. On or about June 6, 2016, Respondent's office date stamped correspondence from Express Scripts pharmacy warning him about the "duplication" of the prescriptions, lorazepam and alprazolam and the potential for "additive side effects" without "further therapeutic benefit." The correspondence indicated that on or about April 30, 2016, Respondent prescribed alprazolam (0.25 mg 4 per day) to Patient A. There was no office visit with Respondent corresponding to this prescription. The same Express Scripts pharmacy record showing the alprazolam (0.25 mg) prescription by Respondent on or about April 30, 2016, also showed the following prescriptions on or about the following dates by another provider: escitalopram, April 9, 2016; alprazolam, April 9, 2016; alprazolam, April 15, 2016; and alprazolam, April 25, 2016.

23. Respondent's next documented visit with Patient A was on or about June 26, 2016. His chart note for this day lists Lexapro® and Xanax®. Respondent prescribed (#0631[3]) Ativan®, Benadryl®, Xanax® (an increase to 0.5 mg, four per day with two refills – 360 pills[4]) and Lexapro® (two refills) to the patient on this date.

24. On or about August 24, 2016, Respondent prescribed (#0461) Ativan®, Benadryl®, Xanax®, and Lexapro® to Patient A. There was no office visit with Respondent corresponding to these prescriptions.

25. Respondent's next documented visit with Patient A was on or about August 28, 2016. The patient complained about attention deficit disorder. Respondent prescribed (#0478) Vyvanse® to her on that date and continued her other medications.

26. In a separate prescription (#0479), dated September 28, 2016, Respondent prescribed Vyvanse® to Patient A. There was no office visit with Respondent corresponding to this prescription.

27. In a separate prescription (#0149), dated October 26, 2016, Respondent prescribed Vyvanse® to Patient A. There was no office visit with Respondent corresponding to this prescription.

28. A handwritten note appears in the middle of a blank preprinted progress note, dated December 28, 2016 and states, "called Xanax® 0.5, QID, #120." When asked about this note in his records, Respondent stated "I do not know . . . what happened here." Respondent was asked, "I don't know why you increased the Xanax® to four here, because there's no explanation." He replied, "I don't have the evidence to support my guess," and provided a speculative answer to the question about the patient possibly feeling "very, very anxious and so on." Respondent was asked, "Is this patient physically or chemically dependent on Xanax® at this moment?" Respondent replied, "I think she is."

29. Respondent's next documented visit with Patient A was on or about December 31, 2016. The patient wanted to stop taking alprazolam. Respondent planned to taper the patient off

[3] The number identified in the parentheses refers to the actual prescription number.
[4] No reason for this was noted in the chart.

alprazolam and continue her other medications. He prescribed Ativan® (#0336), Benadryl® (#0336), Lexapro® (#0336) and Adderall® (#0332) to her on that date.

30. A blank preprinted progress note dated January 16, 2017 appears in the chart.[5]

31. In a separate prescription (#0337), dated January 28, 2017, Respondent also prescribed Xanax® to Patient A. There was no office visit with Respondent corresponding to this prescription.

32. In a separate prescription (#0333), dated January 31, 2017, Respondent also prescribed Adderall XR® to Patient A. There was no office visit with Respondent corresponding to this prescription.

33. In a separate prescription (#0335), dated February 31, 2017, Respondent also prescribed Adderall XR® to Patient A. There was no office visit with Respondent corresponding to this prescription.

34. A blank preprinted progress note dated March 7, 2017 indicates the patient was a "no show."

35. Respondent's next documented visit with Patient A was on or about March 11, 2017. His notes indicate that he prescribed Adderall XR®, Xanax® (0.5 mg, four times daily with three refills (four month supply)) (#1894), Lexapro® (#1894), Ativan® (#1894), and Benadryl® (#1895) to her. Thus, the patient's dosing of alprazolam resumed at the higher level without any comment or inquiry about the taper plan.

36. In a separate prescription (#1891), dated April 1, 2017, Respondent prescribed Adderall® to Patient A. There was no office visit with Respondent corresponding to this prescription.

37. In a separate prescription (#1892), dated May 4, 2017, Respondent prescribed Adderall® to Patient A. There was no office visit with Respondent corresponding to this prescription.

38. In a separate prescription (#1893), dated June 1, 2017, Respondent prescribed

[5] No documentation of any attempt to contact or reschedule the patient was made; thus there was no follow up for the process of the plan for tapering of the patient's alprazolam use.

Adderall® to Patient A. There was no office visit with Respondent corresponding to this prescription.

39. Respondent's next documented visit with Patient A was on or about July 2, 2017. She reported that the amphetamine salts were helping her focus. Respondent prescribed (#0007) Adderall®, Adderall XR® and Ativan® (with two refills) to the patient on that same date.

40. Respondent's chart also includes a note dated July 18, 2017 that Patient A is requesting a refill for lorazapam.

41. In a separate prescription (#1890), dated August 1, 2017, Respondent prescribed Adderall® to Patient A. There was no office visit with Respondent corresponding to this prescription.

42. In a separate prescription (#0008), dated August 2, 2017, Respondent prescribed Xanax® (with two refills) to Patient A. He also signed a prescription (#0009) to the patient for Adderall® and Adderall XR® on that same date. There were no office visits with Respondent corresponding to these prescriptions.

43. In a separate prescription (#0010), dated September 2, 2017, Respondent prescribed Adderall® and Adderall XR® to Patient A. There was no office visit with Respondent corresponding to this prescription.

44. Respondent's next documented visit with Patient A was on or about September 16, 2017. No medications were listed in this chart note. However, Respondent's chart includes a signed prescription (#1538), dated September 16, 2017 for Ativan® and Lexapro®.

45. In a separate prescription (#1541), dated November 16, 2017, Respondent also prescribed Adderall XR® to Patient A. There was no office visit with Respondent corresponding to this prescription.

46. Respondent's next documented visit with Patient A was on or about December 16, 2017. The patient again was attempting to lower her use of Xanax®. However, there was no plan for taper. Instead, Respondent prescribed (#2291) the regular use of Adderall® and Adderall XR® to the patient on that date.

47. In a separate prescription (#2292), dated January 16, 2018, Respondent prescribed

Adderall XR® and Adderall® to Patient A. There was no office visit with Respondent corresponding to this prescription.

48. In a separate prescription (#2293), dated February 16, 2018, Respondent prescribed Adderall XR® and Adderall® to Patient A. There was no office visit with Respondent corresponding to this prescription.

49. Respondent's next documented visit with Patient A was on or about March 28, 2018. Respondent prescribed (#2219) Adderall XR® to the patient on that date. He also wrote a prescription (#2222) dated March 28, 2018 to the patient for Adderal XR®, Lexapro®, Ativan® and Xanax® on that date.

50. In a separate prescription (#2220), dated April 28, 2018, Respondent prescribed Adderall XR® to Patient A. There was no office visit with Respondent corresponding to this prescription.

51. In a separate prescription (#2224), dated May 3, 2018, Respondent prescribed Adderall XR® to Patient A. There was no office visit with Respondent corresponding to this prescription.

52. In a separate prescription (#2221), dated May 28, 2018, Respondent prescribed Adderall XR® to Patient A. There was no office visit with Respondent corresponding to this prescription.

Patient B

53. On or about May 19, 2014, Respondent first saw Patient B, a 55-year-old woman with a history of psychiatric treatment. She came to him after a psychiatric hospitalization in or around April 2014 for lithium toxicity. He diagnosed her with bipolar (I and II) and anxiety disorder and a history of trauma. Patient B had been using Seroquel® (quetiapine), but with poor results, and lorazepam (1 mg every 12 hours). Respondent discontinued the patient's Seroquel® and prescribed Latuda® (40 mg), Restoril® (30 mg at bedtime) and alprazolam (0.25 mg, three per day) to her. Although he noted her medical problems (fibromyalgia, lupus and osteoarthritis), his note did not mention medications for her medical issues. He also did not list hypertension as a problem, despite the condition being listed in her May 5, 2014 hospital consultation record.

54. In a separate prescription (#5-1602), dated May 19, 2014, Respondent prescribed Seroquel®, Xanax®, and Restoril® to Patient B.

55. Respondent's records include hospital consultation records, with admission dates of May 5, 2014 (5150; hypertension (past medical history); suicidal; GAF 30), April 23, 2014 (5150 post lithium toxicity, hospitalized at Las Encinas five weeks prior; Axis III: "refer to internist's notes;"[6] GAF 30); April 20, 2014 (admitted for lithium toxicity; was out of control on admission; GAF 25),[7] which document that the patient had been prescribed Seroquel XR®. Despite these prior hospitalization events indicating lithium toxicity, Respondent failed to order any lithium level laboratory testing. He also failed to monitor the patient's thyroid or renal function, both of which are required when prescribing lithium. Levothyroxine, a thyroid supplement, had been noted on the patient's office visit on or about July 3, 2014 (see below). Respondent also failed to review any laboratory testing results from the patient's hospitalizations.

56. Respondent's next documented visit with Patient B was on or about June 3, 2014. At this visit, Respondent changed his diagnosis to Bipolar, Mixed. His list of her non-psychiatric medications included, propanolol, baclofen and atenolol, but it is unclear whether these were current or past prescriptions. No other medical information was included. He increased her prescriptions, including alprazolam (to 0.5 mg, twice daily and 1 mg at night); Restoril® (temazepam)(to two 30 mg tablets (60 mg) at night, although the highest recommended dose for temazepam is 30 mg); and Latuda® (lurasidone)(to 80 mg). He also added a prescription for lithium (300 mg), and discontinued her lorazepam prescription. In a separate prescription (#5-0155), dated June 3, 2014, Respondent prescribed Restoril® and Xanax® to Patient B.

57. Respondent's next documented visit with Patient B was on or about July 3, 2014. The patient's medication list now included a new drug: levothyroxine. Respondent noted that the patient was prescribed Klonopin® (clonazepam)(1 mg at noon and at bedtime). Respondent

---

[6] However, the internist notes are not in Respondent's records for Patient B.

[7] According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR), a GAF score in the range of 21-30 means "Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends)."

discontinued the patient's prescriptions for Xanax® (alprazolam), Ativan® (lorazepam), Latuda® (lurasidone) and Seroquel® (quetiapine). In a separate prescription (#0777), Respondent also prescribed Klonopin®, temazepam and Benadryl® to Patient B on or about July 3, 2014. In a separate prescription (#5-0777), dated July 3, 2014, Respondent prescribed Klonopin®, temazepam, and Benadryl® to Patient B.

58. Respondent's next documented visit with Patient B was on or about July 15, 2014. The patient complained about "not sleeping at all." Respondent's plan included a prescription for clonazepam (0.5 mg at noon, 1.5 mg at 4 pm and 1 mg at bedtime). However, this is not consistent with the prescription he wrote. His plan also included prescribing Ambien® (zolpidem)(12.5 mg), Benadryl® (100 mg), and Seroquel® (50 mg XR at bedtime), as well as discontinuing Restoril® (temazepam), and a note for lithium, stating "Lithium carbonate 150-300," which was unclear. In a separate prescription (#5-0849), dated July 15, 2014, Respondent prescribed Valium®, Seroquel®, lithium and Klonopin® to Patient B. However, inconsistent with his corresponding chart note for the same date, he wrote a different amount for clonazepam (0.5 mg 1 at noon and 3 at 4 pm, i.e., 4 per day of the 0.5 mg tablets for a quantity of 120 for 30 days). On the prescription of that date, he also wrote for lithium carbonate (300 mg in the morning and 600 mg at night, i.e., a total of 900 mg per day). He also prescribed diazepam (10 mg 2 at bedtime), which did not appear in his corresponding chart note on that date.

59. Respondent's next documented visit with Patient B was on or about August 5, 2014. Respondent wrote that the patient was receiving Thorazine® (chlorpromazine), Valium® (diazepam), doxepin, trazodone and lithium. Despite the fact that Respondent was not prescribing chlorpromazine or doxepin, he did not mention the sources of these medications. The patient was drowsy, forgetful, having some visual hallucinations and psychomotor retardation, and she complained of anxiety. She reported poor balance, which can be a symptom of lithium toxicity. Respondent failed to provide a formal assessment as to the cause of Patient B's altered mental status. He discontinued all her medications except levothyroxine and diazepam. The directions are unclear except not to exceed two Valium® (diazepam) tablets a day. There is no record of any immediate follow up on her mental status over the next four days.

60. On or about August 11, 2014, Respondent's office date stamped correspondence from Express Scripts warning him about Patient B's prescriptions, including her zolpidem and temazepam prescriptions. The correspondence from Express Scripts also showed that Patient A filled a prescription for clonazepam (1 mg, quantity 90), on or about June 11, 2014. Based on this prescription, and Respondent's note, dated June 3, 2014, the patient was now taking alprazolam (0.5 mg twice daily and 1 mg at bedtime), temazepam (60 mg nightly), and clonazepam (1 mg three per day).

61. A handwritten incomplete note (it appears to be missing pages), dated September 7, 2014, shows that the medication list is changed to Restoril® (temazepam) "one at night" (no strength is given), Lexapro® (escitalopram), Effexor® (venlafaxine), Depakote® (divalproex)(500 mg at bedtime), and Xanax® (alprazolam)(0.25 mg at bedtime). Divalproex requires monitoring for liver function and platelet count at a minimum, but no plans for labs were mentioned, nor are any documented in Respondent's records.

62. A pharmacy record from Walgreens indicated that Respondent authorized a refill for alprazolam (0.25 mg, 90 pills) on or about September 17, 2014. However, at his Subject Interview, Respondent could not explain who authorized this refill and claimed that he did not authorize this refill.

63. An Express Scripts pharmacy record shows that on or about September 24, 2014, a prescription for 60 tablets of alprazolam (0.25 mg) was filled as a 30-day supply.

64. In a separate prescription (#6-2800), dated October 10, 2014, Respondent prescribed Depakote®, Rerstoril®, Lexapro®, Xanax® and venlafaxine to Patient B.

65. Respondent's next documented visit with Patient B was on or about October 20, 2014. The patient complained about pain and stated she would see a pain management specialist. However, the only authorization to release records to a pain management group was dated January 5, 2016, two years later. There is no note about coordinating with pain management treatment in Respondent's records. Respondent also increased the patient's alprazolam dose without explanation to 0.25 mg, three per day and temazepam (30 mg at bedtime) was continued. Venlafaxine, escitalopram, and divalproex were all continued.

66. Correspondence from Express Scripts received by Respondent's office on or about December 6, 2014, warned him about excessive doses of temazepam. It showed that Patient B had filled a quantity of 270 of alprazolam (0.25 mg (90-days' supply)) on or about October 20, 2014 and that a refill request was received one week later for alprazolam (0.5 mg quantity 60) on or about October 27, 2014. However, that refill request was denied based on the patient having received the prescription on October 20, 2014. Yet, according to the Express Scripts printout, the patient did fill another prescription written by Dr. A.R., for alprazolam (0.5 mg, quantity 30, a 15 days' supply), on or about October 27, 2014. There is no note from Dr. A.R. in the record concerning this, nor any comments by Respondent concerning the overuse of alprazolam. The Express Scripts printout also showed that on or about October 29, 2014, the patient was prescribed hydrocodone/acetaminophen by another provider (60 pills, 30-days' supply). However, Respondent failed to have and/or document, any discussion with the patient about the risks of combining opioids and benzodiazepines, nor is there any indication in the record that he attempted to coordinate with the other provider.

67. A pharmacy record from Walgreens indicated that on or about January 5, 2015, the patient attempted to obtain a refill and was directed to Dr. A.R., for alprazolam (0.25 mg, quantity 90). The quantity authorized was 90 pills.

68. Respondent's next documented visit with Patient B was on or about January 15, 2015. Respondent's plan included that he would write a prescription for Xanax® (alprazolam), "a 3 month supply" (0.25 mg, 2 -3 a day)." He also continued the patient's prescription for Restoril® (temazepam)(30 mg at bedtime), Lexapro® (escitalopram) and venlafaxine. His plan also included a prescription for Tylenol with Codeine #2 (every 6 hours), but the corresponding prescription copy could not be located. In a separate prescription (#7-1240), dated January 15, 2015, Respondent prescribed Restoril®, venlafaxine, Lexapro®, and Xanax® to Patient B.

69. In a separate prescription (#8-1563), dated March 16, 2015, Respondent prescribed Xanax®, venlafaxine, Lexapro®, and Restoril® to Patient B. There was no office visit with Respondent corresponding to this prescription.

70. In a separate prescription (#7-0788), dated March 24, 2015, Respondent prescribed

Restoril®, venlafaxine, Lexapro®, and Xanax® to Patient B. There was no office visit with Respondent corresponding to this prescription.

71. Respondent's next documented visit with Patient B was on or about April 16, 2015. Respondent's chart note for this visit failed to list any medications as part of his plan. Instead, he wrote, "prescriptions to be sent to Express Scripts to get a 90 day supply." An Express Scripts fax form includes a prescription on that day for Restoril® (temazepam)(30 mg, quantity 90) and Xanax® (alprazolam)(0.25 mg, quantity 70). However, a CURES report in Respondent's records indicated that on or about May 6, 2015, the patient filled a prescription by Respondent for temazepam (30 mg, quantity 60) and again on or about June 4, 2015. Thus, the amount of the patient's one month quantity of temazepam (30 mg) had increased from 30 to 60, without any explanation in the record.

72. On a separate paper that is written in the form of a prescription and not numbered, nor dated, Respondent appeared to prescribe alprazolam, 28, and temazepam to Patient B and a note on the same paper stated that, "last filled and written April 27, 2015." There was no office visit with Respondent corresponding to this prescription.

73. Respondent's next documented visit with Patient B was on or about June 6, 2015. Again, Respondent's chart note for this visit failed to list any medications as part of his plan. Instead, he wrote, "continue current meds." However, a CURES report in Respondent's record indicated that the patient filled a prescription for alprazolam (0.25 mg, 150 pills) on or about June 16, 2015.

74. A CURES report, dated July 8, 2015, indicated that substantial quantities of acetaminophen-codeine were prescribed by two other providers and filled on or about April 13, 2015 and June 24, 2015. Respondent failed to address the Patient's possible overuse of opioids and the risks associated with using a combination of opioids and benzodiazepines.

75. Correspondence from Express Scripts, dated July 16, 2015, to Respondent advised that the prescription for temazepam exceeded the recommended dosing. Respondent acknowledged the "high dose" for temazepam by Respondent to the patient, but responded, "This is the dose that works for my patient."

76. Respondent's next documented visit with Patient B was on or about August 1, 2015. Again, Respondent's chart note for this visit failed to list any medications as part of his plan. Instead, he merely wrote, "continue current program and medications."

77. On or about September 29, 2015, Respondent received another warning from Express Scripts about Patient B's temazepam dose. The correspondence also showed continuing prescriptions for acetaminophen-codeine, on or about July 15, 2015, August 26, 2015, and September 9, 2015, by two different doctors. Respondent failed to address the issues with these prescriptions.

78. On or about October 8, 2015, Express Scripts requested a clarification from Respondent on brand versus generic alprazolam (0.25 mg). In reply, Respondent wrote, "[t]ake one 5 times a day," and authorized a quantity of 600.

79. Respondent's next documented visit with Patient B was on or about January 1, 2016. This was an emergency visit where Respondent planned to admit her to Henry Mayo Hospital on a 5150 hold for suicidality. However, Respondent's records do not include any hospitalization records corresponding to this plan.

80. Correspondence from Express Scripts, reveals that Patient B filled a prescription from Respondent for lorazepam (1 mg, quantity 90), on or about January 4, 2016. However, this prescription was not mentioned in his chart note of that date.

81. Respondent's next documented visit with Patient B was on or about January 9, 2016. Respondent's plan included prescribing the following to the patient: alprazolam (0.25 mg, 5 per day and 1 mg at bedtime), Remeron® (mirtazapine)(15 mg at bedtime), and Geodon® (ziprasidone)(20 mg at bedtime). Correspondence from Express Scripts confirmed the patient filled her prescription for alprazolam on or about January 10, 2016.

82. Respondent's next documented visit with Patient B was on or about January 16, 2016. Respondent described her symptoms, but noted no formal conclusion or assessment. He wrote, "no need to re-hospitalize." He listed her medications as Geodon® (ziprasidone), Restoril® (temazepam)(no doses or frequency), and Xanax® (alprazolam)(0.5 mg, 5 per day and 1 mg at bedtime). This increased her alprazolam dosage to double her previous prescription (0.5 mg five

times daily). This change appears on correspondence from Express Scripts, and such prescription was filled on or about January 16, 2016 (only six days after she filled alprazolam at the 0.25 dosage (quantity 150)). Despite the fact that Patient B appeared to be manic, Respondent prescribed alprazolam to her. But, benzodiazepines are not a treatment for acute mania. They are very risky if given in large quantities to persons whose judgment is impaired or who may be suicidal, as the patient had been a few weeks prior.

83. Respondent was admitted to Henry Mayo Hospital for the time period from on or about January 28, 2016 to on or about February 1, 2016, for agitation, depression, suicidal thoughts, and paranoia. However, Respondent did not adequately address this hospitalization.

84. Respondent received correspondence from Express Scripts on or about February 29, 2016, warning him about his dosing for temazepam that might exceed recommendations. It also showed continuing prescriptions for acetaminophen-codeine in quantities of 150 and 180 by other providers as recently as on or about January 9, 2016 and February 1, 2016. It also showed that on or about March 21, 2016 and March 31, 2016, another provider, Dr. M.S., prescribed diazepam (10 mg strength) to the patient and several prescriptions written by another provider, Dr. A.R., for ziprasidone, mirtazapine, doxepin, and divalproex. Respondent failed to address these additional prescriptions.

85. Respondent's next documented visit with Patient B was on or about March 14, 2016. She complained about sleep problems and anxiety. The patient had been recently released from Henry Mayo Hospital.[8] Respondent's plan included prescribing mirtazapine and Restoril® (temazepam)(60 mg at bedtime), Xanax® (alprazolam)(1 mg, 4 per day and 1 mg at bedtime), divalproex (1000 mg at bedtime), and ziprasidone. The escalation of Respondent's prescription to the patient of the dose for alprazolam (from 0.5 mg, 4 per day and 1 mg at bedtime to 1 mg, 4 per day and 1 mg at bedtime) was confirmed on correspondence from Express Scripts, where the patient filled her prescription for alprazolam (1 mg, quantity 150) on or about April 8, 2016. In a separate prescription (#1-0625), dated March 14, 2016, Respondent prescribed Xanax® and

[8] A faxed document refers to a hospitalization from on or about March 8, 2016 to March 9, 2016.

Restoril® to Patient B.

86. On a separate paper that is written in the form of a prescription and not numbered, Respondent prescribed Geodon®, Remeron® and Depokote® to Patient B on or about March 14, 2016.

87. On a separate paper, dated March 19, 2016, that is written in the form of a prescription and not numbered, Respondent prescribed B12 and a disposable syringe to Patient B.

88. A handwritten chart note, dated April 30, 2016, listed new medications (lurasidone, bupropion), but did not list either alprazolam or temazepam.

89. In a separate prescription (#7-0628), dated June 25, 2016, Respondent prescribed Remeron® and Wellbutrin® to Patient B.

90. In a separate prescription (#7-0630), dated June 25, 2016, Respondent prescribed Serax® and Xanax® to Patient B.

91. Respondent's next documented visit with Patient B was on or about June 26, 2016. In that note, alprazolam (2 mg, four per day), and temazepam (30 mg, two at bedtime) were prescribed. Respondent wrote, "The Xanax is beginning to not help the anxiety." Respondent described the dose escalation of alprazolam, and regarding the current dose (2 mg, four per day), he wrote, "Even at this [dose?] is beginning to really not help." Respondent did not understand the inevitable tolerance that develops with a benzodiazepine when chronically administered. Respondent failed to adequately address the problem of dependence on benzodiazepines, including alprazolam. He continued the patient's prescription for divalproex, but failed to order appropriate laboratory testing. In a separate prescription (#7-0629), dated June 26, 2016, Respondent prescribed Depokote® to Patient B.

92. Respondent's next documented visit with Patient B was on or about August 15, 2016. However, this note failed to list any medications. Nonetheless, in a separate prescription (#2-2176), dated August 15, 2016, Respondent prescribed phentermine, Remeron® (30) and Remeron® (15) to Patient B, and in a separate prescription (#2-2177), dated August 15, 2016, Respondent prescribed Serax® and temazepam to Patient B.

93. On or about August 25, 2016 there was an evaluation for the purposes of authorizing

TMS (transcranial magnetic stimulation).

94. On or about August 30, 2016, Respondent received correspondence from Express Scripts warning him about the combination of oxazepam and alprazolam. The correspondence also revealed that the patient had been filling prescriptions for temazepam, alprazolam, and oxazepam in or around June and July 2016.

95. There is a hiatus in Respondent's records for this patient for seven months, from in or around August, 2016 to in or around March, 2017. However, despite the lack of corresponding patient visits during that time period, Respondent wrote new prescriptions and refilled prescriptions for Patient B, including: alprazolam (on or about September 28, 2016); temazepam (on or about February 9, 2016); Latuda® (#3-0341), dated December 31, 2016; Depakote® and Remeron® (15)(#3-0338), dated December 31, 2016; Remeron® (30)(#3-0339), dated December 31, 2016; and temazepam (#3-0340), dated December 31, 2016.

96. Respondent's next documented visit with Patient B was on or about March 25, 2017. The note contained the patient's thoughts on politics at length, with no problem list and no medication list. Respondent wrote at the bottom, "cont. med," without listing any medications. In separate prescriptions for Patient B, each dated March 25, 2017, Respondent prescribed the following: mirtazapine (#3-1401); temazepam (#3-0999); alprazolam (#3-1000); mirtazapine (#3-0998); oxazepam (#3-0997); and Depakote® (#3-0996).

97. On or about June 26, 2017, Respondent received a phone message from Walgreens, stating, "Concerned on meds she is taking they want all dx and ICD-10 codes can you tell me what they are I only see MDD" This record did not indicate that the diagnosis of bipolar disorder was documented with the prescriptions.

98. Respondent's next documented visit with Patient B was on or about July 31, 2017. The medication list and plan included: divalproex, oxazepam, mirtazepine, alprazolam and temazepam. In a separate prescription (#4-0299), dated July 31, 2017, Respondent prescribed Depakote®, oxazepam, Remeron®, Xanax®, Restoril®, and another drug that is not legible, to Patient B.

99. Respondent's next documented visit with Patient B was on or about September 16,

2017. It listed no medications.

100. On or about September 30, 2017, Respondent received correspondence from Express Scripts warning about the combination of alprazolam and lorazepam. The pharmacy records also revealed that the patient was being prescribed oxazepam (15 mg) and temazepam (30 mg), and that another provider, Dr. A.R., had written prescriptions for temazepam and lorazepam (as well as mirtazepine and amitryptiline) on or about August 24, 2017. However, Respondent failed to address these prescriptions.

101. Respondent's next documented visit with Patient B was on or about October 29, 2017. He wrote that the amitryptiline was helping the patient, but did not record who was prescribing it or who else was seeing her for medications. In a separate prescription (#4-1400), dated October 29, 2017, Respondent prescribed Elavil®, Ativan®, trazodone, Neurontin®, mirtazapine, and Restoril® to Patient B. In another separate prescription (#4-2282), dated October 29, 2017, Respondent prescribed mirtazapine to Patient B.

102. Another handwritten chart note in Respondent's chart is dated December 2, 2017. It listed no medications, merely stated, "continue meds." In a separate prescription (#5-2214), dated December 2, 2017, Respondent prescribed alprazolam (120 with two refills) to Patient B. In another separate prescription (#5-2212), dated December 2, 2017, Respondent prescribed Elavil®, lorazepam, [and another illegible drug] to Patient B. In another separate prescription (#5-2213), dated December 2, 2017, Respondent prescribed trazadone to Patient B.

103. On or about January 13, 2018, Walgreens sent Respondent an authorization request questioning the amount of temazepam he prescribed to the patient. Respondent wrote to the pharmacy, "I believe she needs this medication and it is safe."

104. Another handwritten chart note in Respondent's chart is dated February 17, 2018. The note appears to be incomplete and fails to list the patient's medications.

105. The next documented patient visit was on or about April 14, 2018. The patient's medications included alprazolam. The patient was also receiving additional benzodiazepines: lorazepam and temazepam. Respondent's plan included discontinuing the Ativan® (lorazepam). In a separate prescription (#6-1401), dated April 14, 2018, Respondent prescribed mirtazapine,

trazodone, and Restoril® to Patient B. In another separate prescription (#6-1402), dated April 14, 2018, Respondent prescribed Neurontin®, Xanax®, and Elavil® to Patient B.

106. The last patient visit occurred on or about May 19, 2018.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence and Incompetence)

107. Respondent is subject to disciplinary action under section 2234, subdivisions (b) and (d), of the Code in that Respondent was grossly negligent and/or incompetent in connection with the care and treatment of Patients A and B. The circumstances are as follows: Paragraphs 18 through 106, inclusive, are incorporated herein by reference as if fully set forth.

Patient A.

108. On or about April 13, 2016 and thereafter, Respondent committed the following gross negligence and/or incompetence in connection with Patient A:

A. Respondent failed to perform an adequate medical and/or psychiatric assessment of Patient A before prescribing controlled substances to her. Respondent failed to adequately assess, evaluate, re-assess/re-evaluate, and/or engage the differential diagnosis process and/or establish a medical necessity, and/or document his actions with respect to his treatment of Patient A, in light of her long-term use of controlled substances, including benzodiazepines, and its concomitant potential risks, including the possibility of adverse effects on Patient A's cognitive function, physical health, and mental health (e.g., addiction, dependence, motor impairment, cognitive impairment, impaired motor skills with concern for activities such as driving, and the risk of misuse, dependence, addiction and overdose). He failed to adequately perform on Patient A an assessment (including obtaining her chief complaint; her psychiatric history; her medical history and any current medical conditions; history of substance abuse; current alcohol use and habits; developmental family and social history; legal history if applicable; current medications; and performing a mental status exam) and appropriately derive a list of all problems and diagnoses, and a plan for further information-gathering and/or treatment for each identified problem, and/or document the aforementioned process.

B. Before initiating treatment with benzodiazepines, Respondent failed to attempt

to utilize alternative treatment approaches with Patient A. Respondent failed to adequately advise Patient A about the risks associated with his treatment of her with benzodiazepines (e.g., withdrawal, overdose, car accidents). Respondent failed to recognize tolerance and dependence in Patient A during the time he treated her. Respondent failed to taper the patient off the benzodiazepine drugs he was prescribing, including alprazolam. Multiple daily doses of alprazolam produce tolerance and dependence.

C. Respondent failed to adequately monitor Patient A's prescriptions for benzodiazepines made by other prescribers and/or Patient A's early refills for such prescriptions. Respondent had risk factors for drug abuse and addiction, including her family history of a father and uncle who abused alcohol and drugs, and suffering two DUIs. Respondent repeatedly failed to pay adequate and closer attention to possible misuse. On or about May 3, 2016, Respondent discussed transferring the patient's prescriptions from her primary physician, but he failed to adequately attempt to verify this (e.g., contact the pharmacy or other provider, Dr. T.). Despite the advisement from Express Scripts dated June 6, 2016, Respondent failed to recognize the problem at his patient visit on or about June 26, 2016. On or about October 5, 2016, a pharmacy denied Patient A's alprazolam refill request citing that a prescription was made on or about August 28, 2016 with three refills, but Respondent's charting failed to document that this refill request was a problem. Similarly, Respondent continued to prescribe benzodiazepines to the patient, despite that a post-it note stated that the patient was out of lorazepam 16 days after a quantity of 30 was given.

D. Respondent failed to appropriately prescribe controlled substances to Patient A, and/or failed to adequately document the same. He failed to adequately record each controlled substance prescription for Patient A, including all relevant information (e.g., prescriber, date, refill, rationale), in his medical records. Respondent's records failed to adequately record in a contemporaneous progress note, each prescription that he issued for the patient, and the lack of adequate documentation made it difficult to track which medications the patient was actually receiving from him and when. The record of prescriptions in Respondent's chart does not match the record of patient visits. Respondent's chart includes a set of undated post-it notes of patient

requests for alprazolam. One of these notes states, "Xanax 0.5 tid 90," which appears to be physician's authorization, but has no date. On or about August 28, 2016, Respondent listed the patient's dosage of alprazolam as three per day, but a prescription dated August 24, 2016 lists the dosage as four per day.

E. Respondent failed to adequately re-assess Patient A, diagnose and formulate a treatment plan at each visit with the patient, including listing of her current complaints, problems, ongoing conditions, diagnoses, and plans, and/or document the same. Respondent initially diagnosed Patient A with Anxiety Disorder NOS and depressive episodes at his first visit with her. Later, on or about August 28, 2016, she complained of attention problems and Respondent assessed her and diagnosed her with ADD. However, these problems are not listed in subsequent visit notes, nor addressed with an assessment and plan for each visit. Without separate assessments and plans for each problem, changes in treatment are not assigned to any problem. For example, at her visit on or about March 11, 2017, Respondent changed her prescription from Vyvanse® (lisdexamfetamine) to mixed amphetamine salts, but made no reference to her ADD as a problem in the notes, and failed to adequately document any rationale for this change. Additionally, his chart notes for patient visits on or about each of the following dates do not address the status of, or treatment for, any of Patient A's prior diagnosed problems (e.g., anxiety, ADD): August 28, 2016, December 31, 2016, March 11, 2017, July 2, 2017, and September 16, 2017.

Patient B.

109. On or about May 19, 2014 and thereafter, Respondent committed the following gross negligence and/or incompetence in connection with Patient B:

A. Respondent excessively prescribed benzodiazepines to Patient B, including alprazolam, temazepam and clonazepam, and failed to adequately advise her of the risks of such treatment. Before initiating treatment with benzodiazepines, Respondent failed to attempt to utilize alternative treatment approaches with Patient B. Respondent failed to adequately advise Patient B about the risks associated with his treatment of her with benzodiazepines (e.g., withdrawal, overdose, car accidents). Respondent failed to recognize tolerance and dependence

in Patient B during the time he treated her and this represents incompetence. Respondent failed to taper the patient off the benzodiazepine drugs he was prescribing. On or about May 19, 2014, Respondent initially prescribed to Patient B, alprazolam (25 mg, three per day), but did not indicate whether or not this would be a short-term treatment. Respondent increased the dose of alprazolam over time as the patient developed tolerance, including as early as two weeks after her initial visit. Her daily dosage of alprazolam increased on or about the following dates: January 9, 2016 (2.25 mg); January 16, 2016 (3.5 mg); March 14, 2016 (5 mg); June 26, 2016 (8 mg). This far exceeds normal doses of alprazolam. The regimen creates a serious risk of seizures and psychosis in case of interruption, without any therapeutic benefit. Moreover, on or about June 26, 2016, he wrote that even at the current high dose, the alprazolam was beginning to lose effectiveness. Respondent failed to understand that while increasing the dose of a benzodiazepine may give short-lived anti-anxiety effects, it quickly produces tolerance for the larger dose. In addition, as the benzodiazepine wears off there is impending withdrawal. Respondent wrongly believed that upward dose adjustments would treat anxiety. Respondent also prescribed temazepam at higher than recommended dose levels and was warned about this repeatedly by Express Scripts. Finally, he similarly prescribed to the patient clonazepam at a high dose. Respondent failed to adequately advise the patient about the risks involved with his prescribing, including the dangers of dependence, concomitant use of alcohol or pain medications, driving, or risks of dependence and withdrawal, and fatal respiratory depression.

B. Respondent continued to inappropriately prescribe large quantities of benzodiazepines to Patient B, despite her presentation and failed to adequately monitor the patient. He failed to appreciate the fact that she had episodes of drug-related toxicity and suicidality, and nevertheless allowed early refills of such prescriptions, and continued to place her at risk. The patient had been hospitalized for lithium toxicity. She also presented to Respondent clearly toxic with an altered mental status on one occasion, and was acutely suicidal at another time. She was also hospitalized with suicidal thoughts. Nonetheless, Respondent failed to adequately appreciate the risks, and continued to prescribe large and life threatening quantities of benzodiazepines to Patient B, including: alprazolam and lorazepam. He failed to adequately

appreciate the risks he created, including for lethal overdose and diversion.

C. Respondent failed to understand the risks and lack of benefit of his prescribing of multiple benzodiazepines to Patient B. There is no rationale for prescribing more than one benzodiazepine to Patient B. There is no benefit to Respondent's multiple simultaneous benzodiazepine prescribing to Patient B and that prescribing created increased risks. Combining several benzodiazepines increases the risk of tolerance and dependence, with associated risk of withdrawal, and does not convey any therapeutic benefit. Respondent regularly prescribed alprazolam to Patient B, while she was at times, simultaneously taking at least one and often two other benzodiazepines, including temazepam, oxazepam, clonazepam, and diazepam. Respondent was asked at his Subject Interview about prescriptions for two benzodiazepines, "Why both?" He replied, "Bipolar depression is difficult to deal with" - which demonstrated that Respondent had no rationale for this practice and/or failed to appreciate the risks.

D. Respondent failed to adequately monitor and advise Patient B about the risks of combining opioid and benzodiazepine drugs. Respondent failed to adequately appreciate the risks of combining opioids and benzodiazepines, including the risks of respiratory depression and fatal overdoses. Respondent was aware of the patient's pain management treatment and concomitant opioid prescriptions. Nevertheless, he failed to take appropriate steps to ensure her safety and/or to advise her of the risks, especially in light of her suicidality, and risk of a lethal overdose.

E. Respondent failed to take steps to adequately monitor the controlled substances prescribed to Patient B, including refills. He failed to appreciate that the medications he continued to prescribe to Patient B could lead to diversion and abuse. Treating physicians are responsible for authorizing refills of controlled substances, and if a staff member is delegated to call a pharmacy for a refill, that person should be clearly identified in the record and the order should be signed off by the physician. Respondent's records failed to identify the authors of each refill prescription for controlled substances. Respondent admitted at his Subject Interview that a refill authorization for Patient B's 90 alprazolam pills was written in unknown handwriting - he did not know who wrote it. Similar handwriting appeared on another authorization for an alprazolam refill.

F. Respondent failed to adequately follow-up with Patient B's episode of a likely medication toxicity or over-medication event. On or about August 5, 2014, Patient B suffered altered mental status, which suggested a toxic reaction or over-medication. He discontinued some of her medication. However, Respondent failed to closely monitor Patient B over the succeeding 24 to 48 hours. He failed to document about the patient until on or about September 7, 2014. Respondent failed to adequately follow the patient's condition after the patient's episode on or about August 5, 2014.

G. Respondent failed to adequately follow Patient B who was an unstable bipolar patient. Bipolar patients such as Patient B who exhibit escalating manic behavior, hypomania and/or are depressed and suicidal can be dangerous and should be adequately supervised. If not hospitalized, such patients should be repeatedly assessed for self-harm until adequate resolution of the episodes. Patient B was seen on an emergency basis for acute suicidality on or about January 1, 2016. The written plan was to place her on a hold and hospitalize her. However, there is no record of any hospitalization in or around that date, and the next note is for an office visit five days later. Thus, Respondent failed to adequately monitor her potentially life-threatening suicidal ideation during the five-day period, placing her at risk. On or about January 16, 2016, Patient B presented in a manic state. Although Respondent found that she did not require hospitalization at the time, her next visit with him did not occur until on or about March 14, 2016. There are no notes regarding her course during the interim period. Failure to monitor a manic episode puts the patient at risk of impulsive, self-destructive behaviors. A hospitalization report regarding the period between those two visits, indicated that her situation became critical, but no note from Respondent about admitting her or following her during that period is in his record.

H. Respondent failed to adequately monitor Patient B's use of lithium and divalproex. Treatment with lithium requires that blood levels be measured within appropriate time intervals. Also, Respondent's thyroid and renal status should have been monitored. Divalproex also requires monitoring of liver function and platelet count periodically. On or about July 15, 2104, Respondent prescribed lithium to the patient. She had also recently been hospitalized for lithium toxicity. However, Respondent failed to order appropriate testing and/or

adequately monitor these concerns.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts and Incompetence)

110. Respondent is subject to disciplinary action under section 2234, subdivisions (c) and (d), of the Code in that Respondent committed repeated negligent acts in the care and treatment Patient A, B and C, and/or displayed incompetence. The circumstances are as follows:

111. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth, and represent repeated negligent acts and incompetence.

Patient A

112. In addition, on or about April 13, 2016 and thereafter, Respondent committed the following negligence and/or incompetence in connection with Patient A:

A. Respondent prescribed more than one benzodiazepine to Patient A concurrently. Respondent prescribed both lorazepam and alprazolam to Patient A. On or about June 6, 2016, Express Scripts sent an advisement to Respondent warning him ("Patients who receive duplicative therapy may exhibit additive side effects.") about the combination. Nevertheless, he continued the combination without an adequately documented justification.

Patient B

113. In addition, on or about May 19, 2014 and thereafter, Respondent committed the following negligence and/or incompetence in connection with Patient B:

A. Respondent failed to adequately assess the patient and perform an initial evaluation of her. At his initial visit with Patient B, a psychiatric patient, Respondent failed to adequately perform and/or document a comprehensive medical history, including current conditions and medical treatments, and to identify primary care providers, including ensuring that Patient B was not suffering from a medical condition masquerading as a psychiatric condition. At his initial visit with Patient B, Respondent failed to list her treatment for her various medical concerns. A list of those problems appeared again at the visit on or about May 26, 2016. Although hypertension appeared in a hospital note, and Respondent documented propranol and atenolol in a note, he never listed hypertension as a medical problem. He also documented

levothyroxine but failed to monitor her thyroid status. Similarly, he mentioned lupus without any further investigation.

B. Respondent failed to maintain adequate records for Patient B. Respondent's records failed to include adequately identified problems (including the patient's chief complaint and ongoing conditions), assessments, and plans. Initially he diagnosed the patient with Bipolar I or II, and Anxiety Disorder. Later, when the patient was seriously depressed and suicidal, Respondent failed to adequately address her bipolar condition and include an assessment and plan in his records. Similarly, he failed to reference the patient's bipolar diagnosis when he described manic symptoms at another visit. Respondent listed several problems for the patient in a letter dated May 26, 2016, including bipolar disorder, anxiety, irritability, lupus, arthritis, fibromyalgia, and history of trauma. However, this list does not appear in his recorded patient visit records.

C. Respondent's medical records were incomplete, inadequate and inaccurate. Each record that includes a plan with a prescription should have a corresponding written prescription that matches a patient visit. However, Respondent's records included prescriptions that did not correspond with patient visits and plans that did not have corresponding written prescriptions. He also failed to list all of the patient's current medications at each visit, and changes to her doses for medications were not adequately documented. In addition, the patient's hospitalizations were not adequately documented, with pertinent data, including the cause of the hospitalization, the course, and the discharge status, which should have been summarized in the outpatient notes. Some notes were not dated, nor signed by Respondent. His records included patient visit chart notes that failed to list any medications other than a statement, "prescriptions to be sent to Express Scripts for a 90 day supply" or "continue current meds." Patient A was also hospitalized twice while under Respondent's care as an outpatient, namely in or around the period beginning on or about January 29, 2016 through on or about February 1, 2016 and again during the period beginning on or about March 8, 2016 through March 9, 2016. There are no notes by Respondent in the record regarding these hospitalizations, their causes or outcomes.

D. Respondent failed to adequately coordinate his care for Patient B with her other treatment providers, including her primary care physician. Respondent failed to adequately

mange her medications that could interact and affect her mental status. Coordination of care reduces the risk of possible incompatible treatments by different providers. While Respondent's records included an authorization for the release of records to a pain management group, he failed to contact the pain management provider. Respondent failed to address Patient B's numerous prescriptions for pain medications that appeared in correspondence from Express Scripts. Given the patient's unstable moods and suicidal tendencies, Respondent should have carefully monitored her drug use in order to avoid possible dangerous overdoses. Despite his records documenting that a primary care provider was to evaluate her for possible TMS (transcranial magnetic stimulation) treatment and that the patient took medications to manage her thyroid and hypertension, there is no evidence he ever contacted a primary care doctor to coordinate care.

E. Respondent failed to adequately address the other prescriptions Patient B received from other providers. Respondent knew that on or about October 27, 2014, another provider, Dr. A.R., wrote a prescription for alprazolam. But, he failed to address this. Dr. A.J. also wrote prescriptions for ziprasidone, mirtazapine, doxepin, divalproex, lorazepam, temazepam and amitryptiline, but there are no notes from him in the record. When there are multiple prescribers who are not communicating via a single medical record, the patient is at risk for adverse medication interactions.

Factual Allegations: Patient C

114. On or about April 16, 2013, Respondent first saw Patient C, a 46-year-old man with a history of ADD and depression for 20 years. The patient's medication list included: Vyvanse® (70 mg); Lexapro® (20 mg); Xanax® (1 mg); and AndroGel®. Respondent's diagnosis included, "ADHD, major depression [illegible – DO?], recurrent non-psychotic." Respondent's plan was to increase the patient's prescription for Lexapro® (to 30 mg per day), and to add prescriptions for Adderall® XR (30 mg bid) and Abilify®.

115. Thereafter, Respondent continued to treat Patient C until at least in or around May 19, 2018. During this treatment period, the patient's medical records are replete with additional communications from the patient regarding prescription requests, adjustments, and special circumstances (i.e., prescriptions thrown away, confiscated or needed for travel). After his initial

visit with Respondent, the record includes 21 dated entries for 2013 (including 10 letters), which included requests for early refills due to travel, and requests to increase prescription strength. Respondent's records for the following years were similar to 2013 and replete with such requests and correspondence.

116. At his Subject Interview, Respondent acknowledged that Patient C was an addict. But, Respondent stated that he did not recognize that Patient C was an addict until the "last 12 months, six months, seven months, eight months [since March 21, 2019]." He stated that in the beginning, the patient "needed something for his ADD," and depression. He further explained that in the beginning, it looked like he had depression and anxiety as well, and he gave him medications to treat those conditions. He also stated that the patient wrote him "all of these notes because he wants me to be sure." He then explained that he was beginning to see that the patient was dependent on prescription medications. However, he did cooperate with his requests, and at his Subject Interview, Respondent stated that maybe he should have verified some of the patient's special requests, e.g., when the patient wanted three pills for an airplane trip to New Mexico, he should have asked to see a ticket. When asked about Patient C repeatedly losing his prescriptions or that they were stolen from him or confiscated at the airport, Respondent "accepted some of that," but did not remember the patient losing any prescriptions. Respondent also acknowledged that he accommodated the patient's special prescription requests on or about March 25, 2014, to obtain Adderall as a "separate 'script' [he] will fill it a few days later," followed by a letter written on that same date, referring to the need for prescriptions to be written on that day due to impending travel plans by the patient. Respondent also acknowledged a request by the patient to change the date of an already post-dated prescription [which is essentially an illicit refill] for Adderall®[9] in a letter dated July 17, 2014. They also discussed an email, dated August 20, 2014, wherein Patient C proposed to follow Patient C's own treatment regimen to Respondent, and a letter faxed on or about November 10, 2014, wherein Patient C apologized to Respondent for "ever drawing the kind of federal (DEA) attention [to Respondent] and whereon he wrote by hand, "I will call and make my payment as well." And, Respondent stated that Patient C was his

[9] Respondent admitted to this at his Subject Interview.

"most difficult patient." Despite Respondent's claim that he became aware that Patient C was an addict only as early as March 2019, on or about November 20, 2014, Respondent saw Patient C and "discussed the mal-use and abuse of Xanax®, other prescriptions not found, confronted patient with his addiction and dependence." And, "now saying he wants to get rid of Xanax." However, in an email dated November 20, 2014, the patient complained to Respondent that he did not have enough alprazolam, and suffered intense discomfort after trying not to take any alprazolam. In or around October 2015, the patient alleged that his prescriptions were thrown away.

117. On or about April 16, 2013 and thereafter, Respondent committed negligence when he failed to set adequate limits on Patient C's drug seeking behavior. Respondent failed to recognize and adequately address Patient C's manipulative, drug-seeking behavior, including demanding early refills, allegedly losing prescriptions, and requesting changes in dosages and medications. For example, such issues (e.g., if a patient alleges that they threw their medications away) could be addressed by providing the patient with only a partial refill, or dispensing the medication weekly instead of monthly. Respondent did not adequately monitor Patient C's drug seeking behavior. He refilled the patient's prescriptions after he alleged to have lost them, or threw them away, or had them confiscated by customs. He also failed to adequately address the patient's barrage of faxes, letters, and emails to him requesting early refills or changes in medication. At the next visit after such a drug-seeking episode, Respondent would fail to adequately address such behavior, and continued to recommend medication to the patient.

118. On or about April 16, 2013 and thereafter, Respondent committed negligence when he prescribed two forms of Wellbutrin at the same time without adequately assessing the patient and documenting his reasoning for this combination of medications. Respondent prescribed Wellbutrin XL (300 mg) and Wellbutrin (IR or SR, 100 mg) concurrently without adequately documenting his reason for this contraindicated combination drug treatment. On or about November 13, 2014, Respondent prescribed to Patient C, Wellbutrin® XL (300 mg, AM) and Wellbutrin (100 mg AM). He prescribed this combination again on or about May 15, 2015, i.e., Wellbutrin® XL and bupropion HCL (100 mg). On or about June 10, 2015, Patient C requested

that Respondent prescribe this combination to him again.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

119. Respondent is subject to disciplinary action under section 2234, subdivision (d), of the Code in that Respondent was incompetent. The circumstances are as follows:

120. The allegations of the First and Second Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Record Keeping)

121. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records relating to the provision of services to patients. The circumstances are as follows:

122. The allegations of the First, Second and Third Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth. In addition, Respondent's records are inadequate and lack a corresponding office visit for each prescription he wrote.

FIFTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

123. Respondent is subject to disciplinary action under section 725 of the Code in that Respondent excessively prescribed medications to patients. The circumstances are as follows:

124. The allegations of the First, Second, Third and Fourth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination)

125. Respondent is subject to disciplinary action under section 2242 of the Code, in that Respondent prescribed drugs to Patient A, B and C above, without appropriate prior examinations and/or medical indications. The circumstances are as follows:

126. The allegations of the First, Second, Third, Fourth and Fifth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(Violation of Drug Statute; Dishonest, Corrupt Acts)

127. Respondent is subject to disciplinary action under section 2238 and 2234, subdivision (e) of the Code and sections 11190 and 11200 of the Health and Safety Code and section 829 of Title 21 of the United States Code, section 1306.05, subdivision (a) of Title 21 of the Code of Federal Regulations in that Respondent failed to issue correct prescriptions and/or make a correct record of his prescriptions to his patients for controlled substances and/or post-dated his prescriptions and failed to include the actual date of his prescriptions, and this constituted dishonest and/or corrupt acts in an attempt to circumvent the proscriptions against refills of Schedule II controlled substances; and failed to register under the CURES program as required by law. The circumstances are as follows:

128. The allegations of the First, Second, Third, Fourth, Fifth, Sixth and Seventh Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

EIGHTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

129. Respondent is subject to disciplinary action under section 2234 of the Code in that Respondent has engaged in unprofessional conduct, generally. The circumstances are as follows:

130. The allegations of the First, Second, Third, Fourth, Fifth, Sixth and Seventh Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth, and represent unprofessional conduct.

///

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number C 38408, issued to Thor-Alcyone Lopez Reyes, M.D.;

2. Revoking, suspending or denying approval of Thor-Alcyone Lopez Reyes, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Thor-Alcyone Lopez Reyes, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: April 10, 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2020500569
63197273.docx