

**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 01 2020.

IT IS SO ORDERED SEP 24 2020.

MEDICAL BOARD OF CALIFORNIA



**William Prasifka
Executive Director**

1 XAVIER BECERRA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 EDWARD KIM
Deputy Attorney General
4 State Bar No. 195729
California Department of Justice
5 300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
6 Telephone: (213) 269-6000
Facsimile: (916) 731-2117
7 *Attorneys for Complainant*

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In the Matter of the Accusation Against:

Case No. 800-2017-038136

12 **THOR-ALCYONE LOPEZ REYES, M.D.**

13 **Physician's and Surgeon's**
14 **Certificate No. C 38408,**

STIPULATED SURRENDER OF
LICENSE AND ORDER

15 Respondent.

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

18 **PARTIES**

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

23 2. THOR-ALCYONE LOPEZ REYES, M.D. (Respondent) is represented in this
24 proceeding by attorney Carlo Reyes, whose address is: 893 Patriot Dr., Unit A, Moorpark CA
25 93021-3357.

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

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

3 **JURISDICTION**

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

9 **ADVISEMENT AND WAIVERS**

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

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

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

22 **CULPABILITY**

23 8. Respondent understands that the charges and allegations in Accusation No. 800-2017-
24 038136, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and
25 Surgeon's Certificate.

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

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

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

6 CONTINGENCY

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

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

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

21 ORDER

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

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

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

3 DATED: 8/2/20 Carlo Reyes MD Esq.
4 CARLO M. REYES
Attorney for Respondent

5
6 **ENDORSEMENT**

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

9 DATED: _____

Respectfully submitted,
10 XAVIER BECERRA
Attorney General of California
11 JUDITH T. ALVARADO
Supervising Deputy Attorney General

12
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14 EDWARD KIM
Deputy Attorney General
Attorneys for Complainant

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

3 DATED: _____ CARLO M. REYES
4 *Attorney for Respondent*

5
6 **ENDORSEMENT**

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

9 DATED: 8-18-20 Respectfully submitted,
10 XAVIER BECERRA
11 Attorney General of California
12 JUDITH T. ALVARADO
13 Supervising Deputy Attorney General

14 
15 EDWARD KIM
16 Deputy Attorney General
17 *Attorneys for Complainant*

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Exhibit A

Accusation No. 800-2017-038136

1 XAVIER BECERRA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 EDWARD KIM
Deputy Attorney General
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8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2017-038136

13 **THOR-ALCYONE LOPEZ REYES, M.D.**
893 Patriot Drive, Bldg. J, Unit A
Moorpark, CA 93021

A C C U S A T I O N

14 **Physician's and Surgeon's**
15 **Certificate No. C 38408,**

16 Respondent.

17 **PARTIES**

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

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

25 **JURISDICTION**

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

1 STATUTORY PROVISIONS

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

6 5. Section 2234 of the Code, states:

7 The board shall take action against any licensee who is charged with
8 unprofessional conduct. In addition to other provisions of this article, unprofessional
9 conduct includes, but is not limited to, the following:

10 (a) Violating or attempting to violate, directly or indirectly, assisting in or
11 abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

12 (c) Repeated negligent acts. To be repeated, there must be two or more
13 negligent acts or omissions. An initial negligent act or omission followed by a
14 separate and distinct departure from the applicable standard of care shall constitute
15 repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically
16 appropriate for that negligent diagnosis of the patient shall constitute a single
17 negligent act.

18 (2) When the standard of care requires a change in the diagnosis, act, or
19 omission that constitutes the negligent act described in paragraph (1), including, but
20 not limited to, a reevaluation of the diagnosis or a change in treatment, and the
21 licensee's conduct departs from the applicable standard of care, each departure
22 constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

23 (e) The commission of any act involving dishonesty or corruption that is
24 substantially related to the qualifications, functions, or duties of a physician and
25 surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

26 (g) The failure by a certificate holder, in the absence of good cause, to attend
27 and participate in an interview by the board. This subdivision shall only apply to a
28 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:

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

5 (b) A physician and surgeon may prescribe, dispense, or administer prescription
6 drugs or prescription controlled substances to an addict for purposes of maintenance
7 on, or detoxification from, prescription drugs or controlled substances only as set
8 forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and
9 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a
10 physician and surgeon to prescribe, dispense, or administer dangerous drugs or
11 controlled substances to a person he or she knows or reasonably believes is using or
12 will use the drugs or substances for a nonmedical purpose.

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

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

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

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

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

27 (A) Impaired control over drug use.

28 (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

1 following:

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

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

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

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

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

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

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

27 (d) A physician and surgeon shall exercise reasonable care in determining
28 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 (1) The licensee was a designated physician and surgeon or podiatrist serving in
2 the absence of the patient's physician and surgeon or podiatrist, as the case may be,
3 and if the drugs were prescribed, dispensed, or furnished only as necessary to
4 maintain the patient until the return of the patient's practitioner, but in any case no
5 longer than 72 hours.

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

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

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

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

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

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

23 11. Health and Safety Code § 11165 states:

24 (a) To assist health care practitioners in their efforts to ensure appropriate
25 prescribing, ordering, administering, furnishing, and dispensing of controlled
26 substances, law enforcement and regulatory agencies in their efforts to control the
27 diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled
28 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,

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

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

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

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

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

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

28 (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

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

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

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

8 (5) Quantity of the controlled substance dispensed.

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

11 (7) Number of refills ordered.

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

14 (9) Date of origin of the prescription.

15 (10) Date of dispensing of the prescription.

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

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

23 (f) The Department of Justice shall, prior to upgrading CURES, consult with
24 prescribers licensed by one of the boards or committees identified in subdivision (d)
25 of Section 208 of the Business and Professions Code, one or more of the boards or
26 committees identified in subdivision (d) of Section 208 of the Business and
27 Professions Code, and any other stakeholder identified by the department, for the
28 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.

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

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

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

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

17 12. Health and Safety Code § 11165.1 states:

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

28 (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,

1 or to document compliance with the law.

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

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

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

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

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

26 (I) The date of the query.

27 (II) The time of the query.

28 (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.

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

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

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

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

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

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

26 (c) In order to prevent the inappropriate, improper, or illegal use of Schedule II,
27 Schedule III, or Schedule IV controlled substances, the Department of Justice may
28 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
2 (1) "Automated basis" means using predefined criteria to trigger an automated
3 query to the CURES database, which can be attributed to a specific health care
4 practitioner or pharmacist.

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

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

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

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

20 (h) This section shall become inoperative on July 1, 2021, or upon the date the
21 department promulgates regulations to implement this section and posts those
22 regulations on its internet website, whichever date is earlier, and, as of January 1,
23 2022, is repealed.

24 13. Health and Safety Code § 11165.4 states:

25 (a) (1) (A) (i) A health care practitioner authorized to prescribe, order,
26 administer, or furnish a controlled substance shall consult the CURES database to
27 review a patient's controlled substance history before prescribing a Schedule II,
28 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

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

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

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

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

12 (A) A licensed clinic, as described in Chapter 1 (commencing with Section
13 1200) of Division 2.

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

16 (C) A health facility, as described in Chapter 2 (commencing with Section
17 1250) of Division 2.

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

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

25 (3) If a health care practitioner prescribes, orders, administers, or furnishes a
26 controlled substance to a patient as part of the patient's treatment for a surgical
27 procedure and the quantity of the controlled substance does not exceed a nonrefillable
28 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

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

2 (h) This section shall become inoperative on July 1, 2021, or upon the date the
3 department promulgates regulations to implement this section and posts those
4 regulations on its internet website, whichever date is earlier, and, as of January 1,
5 2022, is repealed.

6 14. Section 725 of the Code states:

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

14 (b) Any person who engages in repeated acts of clearly excessive prescribing or
15 administering of drugs or treatment is guilty of a misdemeanor and shall be punished
16 by a fine of not less than one hundred dollars (\$100) nor more than six hundred
17 dollars (\$600), or by imprisonment for a term of not less than 60 days nor more than
18 180 days, or by both that fine and imprisonment.

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

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

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

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

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

28 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

1 hyperactivity disorder, but also has a high potential for abuse. It is a Schedule II
2 controlled substance pursuant to Health and Safety Code section 11055, subdivision
3 (d)(1), and a dangerous drug as defined in Business and Professions Code section
4 4022.

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

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

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

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

37 “Ativan®”: see lorazepam, below.

38 “Benadryl®”: see diphenhydramine, below.

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

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

10
11 “Bupropion” is an antidepressant medication used to treat major depression
12 and to assist with smoking cessation. It is also sold under various brand names
13 including, Wellbutrin®, Zyban®, Voxra® and Budeprion®, among others. It is a
14 dangerous drug as defined in Business and Professions Code section 4022.

15
16 “Clonazepam” is a benzodiazepine-based sedative. It is generally used to
17 control seizures and panic disorder. It is sold under the brand name Klonopin®. It
18 is a Schedule IV controlled substance pursuant to Health and Safety Code section
19 11057, subdivision (d)(7), and a dangerous drug as defined in Business and
20 Professions Code section 4022.

21
22 “Chlorpromazine” is an antipsychotic medication. It is primarily used to
23 treat psychotic disorders such as schizophrenia or manic-depression in adults. It is
24 also used to treat bipolar disorder, severe behavioral problems in children including
25 those with attention deficit hyperactivity disorder, nausea and vomiting, anxiety
26 before surgery, and hiccups. It is sold under the brand names Thorazine® and
27 Largactil®, among others. It is a dangerous drug as defined in Business and
28 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

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

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

11 “Elavil®”: see amitriptyline, above.

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

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

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

27 “Including” means including, without limitation.

28 “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

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

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

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

11 "Neurontin®": see gabapentin, above.

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

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

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

27 "Serax®": see oxazepam, above.

28 "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.

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

7 “Vyvanse®”: see lisdexamfetamine, above.

8 “Wellbutrin®”: see bupropion, above.

9 “Xanax®”: see alprazolam, above.

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

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

20 **FACTUAL ALLEGATIONS: Patients A and B**

21 Subject Interview

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

28 Patient A¹

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

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

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

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

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

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

20 22. On or about June 6, 2016, Respondent’s office date stamped correspondence from
21 Express Scripts pharmacy warning him about the “duplication” of the prescriptions, lorazepam
22 and alprazolam and the potential for “additive side effects” without “further therapeutic benefit.”
23 The correspondence indicated that on or about April 30, 2016, Respondent prescribed alprazolam
24 (0.25 mg 4 per day) to Patient A. There was no office visit with Respondent corresponding to
25 this prescription. The same Express Scripts pharmacy record showing the alprazolam (0.25 mg)
26 prescription by Respondent on or about April 30, 2016, also showed the following prescriptions
27 on or about the following dates by another provider: escitalopram, April 9, 2016; alprazolam,
28 April 9, 2016; alprazolam, April 15, 2016; and alprazolam, April 25, 2016.

1 23. Respondent's next documented visit with Patient A was on or about June 26, 2016.
2 His chart note for this day lists Lexapro® and Xanax®. Respondent prescribed (#0631³)
3 Ativan®, Benadryl®, Xanax® (an increase to 0.5 mg, four per day with two refills – 360 pills⁴)
4 and Lexapro® (two refills) to the patient on this date.

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

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

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

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

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

25 29. Respondent's next documented visit with Patient A was on or about December 31,
26 2016. The patient wanted to stop taking alprazolam. Respondent planned to taper the patient off

27 _____
28 ³ The number identified in the parentheses refers to the actual prescription number.

⁴ No reason for this was noted in the chart.

1 alprazolam and continue her other medications. He prescribed Ativan® (#0336), Benadryl®
2 (#0336), Lexapro® (#0336) and Adderall® (#0332) to her on that date.

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

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

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

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

13 34. A blank preprinted progress note dated March 7, 2017 indicates the patient was a “no
14 show.”

15 35. Respondent’s next documented visit with Patient A was on or about March 11, 2017.
16 His notes indicate that he prescribed Adderall XR®, Xanax® (0.5 mg, four times daily with three
17 refills (four month supply)) (#1894), Lexapro® (#1894), Ativan® (#1894), and Benadryl®
18 (#1895) to her. Thus, the patient’s dosing of alprazolam resumed at the higher level without any
19 comment or inquiry about the taper plan.

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

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

26 38. In a separate prescription (#1893), dated June 1, 2017, Respondent prescribed
27

28 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.

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

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

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

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

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

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

18 44. Respondent's next documented visit with Patient A was on or about September 16,
19 2017. No medications were listed in this chart note. However, Respondent's chart includes a
20 signed prescription (#1538), dated September 16, 2017 for Ativan® and Lexapro®.

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

24 46. Respondent's next documented visit with Patient A was on or about December 16,
25 2017. The patient again was attempting to lower her use of Xanax®. However, there was no
26 plan for taper. Instead, Respondent prescribed (#2291) the regular use of Adderall® and Adderall
27 XR® to the patient on that date.

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

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

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

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

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

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

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

19 Patient B

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

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

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

13 56. Respondent's next documented visit with Patient B was on or about June 3, 2014. At
14 this visit, Respondent changed his diagnosis to Bipolar, Mixed. His list of her non-psychiatric
15 medications included, propranolol, baclofen and atenolol, but it is unclear whether these were
16 current or past prescriptions. No other medical information was included. He increased her
17 prescriptions, including alprazolam (to 0.5 mg, twice daily and 1 mg at night); Restoril®
18 (temazepam)(to two 30 mg tablets (60 mg) at night, although the highest recommended dose for
19 temazepam is 30 mg); and Latuda® (lurasidone)(to 80 mg). He also added a prescription for
20 lithium (300 mg), and discontinued her lorazepam prescription. In a separate prescription (#5-
21 0155), dated June 3, 2014, Respondent prescribed Restoril® and Xanax® to Patient B.

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

25 _____
26 ⁶ However, the internist notes are not in Respondent's records for Patient B.

27 ⁷ According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
28 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)."

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

6 58. Respondent's next documented visit with Patient B was on or about July 15, 2014.
7 The patient complained about "not sleeping at all." Respondent's plan included a prescription for
8 clonazepam (0.5 mg at noon, 1.5 mg at 4 pm and 1 mg at bedtime). However, this is not
9 consistent with the prescription he wrote. His plan also included prescribing Ambien®
10 (zolpidem)(12.5 mg), Benadryl® (100 mg), and Seroquel® (50 mg XR at bedtime), as well as
11 discontinuing Restoril® (temazepam), and a note for lithium, stating "Lithium carbonate 150-
12 300," which was unclear. In a separate prescription (#5-0849), dated July 15, 2014, Respondent
13 prescribed Valium®, Seroquel®, lithium and Klonopin® to Patient B. However, inconsistent
14 with his corresponding chart note for the same date, he wrote a different amount for clonazepam
15 (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
16 days). On the prescription of that date, he also wrote for lithium carbonate (300 mg in the
17 morning and 600 mg at night, i.e., a total of 900 mg per day). He also prescribed diazepam (10
18 mg 2 at bedtime), which did not appear in his corresponding chart note on that date.

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

1 60. On or about August 11, 2014, Respondent's office date stamped correspondence from
2 Express Scripts warning him about Patient B's prescriptions, including her zolpidem and
3 temazepam prescriptions. The correspondence from Express Scripts also showed that Patient A
4 filled a prescription for clonazepam (1 mg, quantity 90), on or about June 11, 2014. Based on this
5 prescription, and Respondent's note, dated June 3, 2014, the patient was now taking alprazolam
6 (0.5 mg twice daily and 1 mg at bedtime), temazepam (60 mg nightly), and clonazepam (1 mg
7 three per day).

8 61. A handwritten incomplete note (it appears to be missing pages), dated September 7,
9 2014, shows that the medication list is changed to Restoril® (temazepam) "one at night" (no
10 strength is given), Lexapro® (escitalopram), Effexor® (venlafaxine), Depakote®
11 (divalproex)(500 mg at bedtime), and Xanax® (alprazolam)(0.25 mg at bedtime). Divalproex
12 requires monitoring for liver function and platelet count at a minimum, but no plans for labs were
13 mentioned, nor are any documented in Respondent's records.

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

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

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

22 65. Respondent's next documented visit with Patient B was on or about October 20,
23 2014. The patient complained about pain and stated she would see a pain management specialist.
24 However, the only authorization to release records to a pain management group was dated
25 January 5, 2016, two years later. There is no note about coordinating with pain management
26 treatment in Respondent's records. Respondent also increased the patient's alprazolam dose
27 without explanation to 0.25 mg, three per day and temazepam (30 mg at bedtime) was continued.
28 Venlafaxine, escitalopram, and divalproex were all continued.

1 66. Correspondence from Express Scripts received by Respondent's office on or about
2 December 6, 2014, warned him about excessive doses of temazepam. It showed that Patient B
3 had filled a quantity of 270 of alprazolam (0.25 mg (90-days' supply)) on or about October 20,
4 2014 and that a refill request was received one week later for alprazolam (0.5 mg quantity 60) on
5 or about October 27, 2014. However, that refill request was denied based on the patient having
6 received the prescription on October 20, 2014. Yet, according to the Express Scripts printout, the
7 patient did fill another prescription written by Dr. A.R., for alprazolam (0.5 mg, quantity 30, a 15
8 days' supply), on or about October 27, 2014. There is no note from Dr. A.R. in the record
9 concerning this, nor any comments by Respondent concerning the overuse of alprazolam. The
10 Express Scripts printout also showed that on or about October 29, 2014, the patient was
11 prescribed hydrocodone/acetaminophen by another provider (60 pills, 30-days' supply).
12 However, Respondent failed to have and/or document, any discussion with the patient about the
13 risks of combining opioids and benzodiazepines, nor is there any indication in the record that he
14 attempted to coordinate with the other provider.

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

18 68. Respondent's next documented visit with Patient B was on or about January 15, 2015.
19 Respondent's plan included that he would write a prescription for Xanax® (alprazolam), "a 3
20 month supply" (0.25 mg, 2 -3 a day)." He also continued the patient's prescription for Restoril®
21 (temazepam)(30 mg at bedtime), Lexapro® (escitalopram) and venlafaxine. His plan also
22 included a prescription for Tylenol with Codeine #2 (every 6 hours), but the corresponding
23 prescription copy could not be located. In a separate prescription (#7-1240), dated January 15,
24 2015, Respondent prescribed Restoril®, venlafaxine, Lexapro®, and Xanax® to Patient B.

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

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

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

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

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

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

21 74. A CURES report, dated July 8, 2015, indicated that substantial quantities of
22 acetaminophen-codeine were prescribed by two other providers and filled on or about April 13,
23 2015 and June 24, 2015. Respondent failed to address the Patient's possible overuse of opioids
24 and the risks associated with using a combination of opioids and benzodiazepines.

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

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

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

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

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

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

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

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

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

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

10 84. Respondent received correspondence from Express Scripts on or about February 29,
11 2016, warning him about his dosing for temazepam that might exceed recommendations. It also
12 showed continuing prescriptions for acetaminophen-codeine in quantities of 150 and 180 by other
13 providers as recently as on or about January 9, 2016 and February 1, 2016. It also showed that on
14 or about March 21, 2016 and March 31, 2016, another provider, Dr. M.S., prescribed diazepam
15 (10 mg strength) to the patient and several prescriptions written by another provider, Dr. A.R., for
16 ziprasidone, mirtazapine, doxepin, and divalproex. Respondent failed to address these additional
17 prescriptions.

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

27 _____
28 ⁸ A faxed document refers to a hospitalization from on or about March 8, 2016 to
March 9, 2016.

1 Restoril® to Patient B.

2 86. On a separate paper that is written in the form of a prescription and not numbered,
3 Respondent prescribed Geodon®, Remeron® and Depokote® to Patient B on or about March 14,
4 2016.

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

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

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

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

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

23 92. Respondent's next documented visit with Patient B was on or about August 15, 2016.
24 However, this note failed to list any medications. Nonetheless, in a separate prescription (#2-
25 2176), dated August 15, 2016, Respondent prescribed phentermine, Remeron® (30) and
26 Remeron® (15) to Patient B, and in a separate prescription (#2-2177), dated August 15, 2016,
27 Respondent prescribed Serax® and temazepam to Patient B.

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

1 TMS (transcranial magnetic stimulation).

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

6 95. There is a hiatus in Respondent's records for this patient for seven months, from in or
7 around August, 2016 to in or around March, 2017. However, despite the lack of corresponding
8 patient visits during that time period, Respondent wrote new prescriptions and refilled
9 prescriptions for Patient B, including: alprazolam (on or about September 28, 2016); temazepam
10 (on or about February 9, 2016); Latuda® (#3-0341), dated December 31, 2016; Depakote® and
11 Remeron® (15)(#3-0338), dated December 31, 2016; Remeron® (30)(#3-0339), dated December
12 31, 2016; and temazepam (#3-0340), dated December 31, 2016.

13 96. Respondent's next documented visit with Patient B was on or about March 25, 2017.
14 The note contained the patient's thoughts on politics at length, with no problem list and no
15 medication list. Respondent wrote at the bottom, "cont. med," without listing any medications.
16 In separate prescriptions for Patient B, each dated March 25, 2017, Respondent prescribed the
17 following: mirtazapine (#3-1401); temazepam (#3-0999); alprazolam (#3-1000); mirtazapine (#3-
18 0998); oxazepam (#3-0997); and Depakote® (#3-0996).

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

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

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

1 2017. It listed no medications.

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

8 101. Respondent's next documented visit with Patient B was on or about October 29,
9 2017. He wrote that the amitriptyline was helping the patient, but did not record who was
10 prescribing it or who else was seeing her for medications. In a separate prescription (#4-1400),
11 dated October 29, 2017, Respondent prescribed Elavil®, Ativan®, trazodone, Neurontin®,
12 mirtazapine, and Restoril® to Patient B. In another separate prescription (#4-2282), dated
13 October 29, 2017, Respondent prescribed mirtazapine to Patient B.

14 102. Another handwritten chart note in Respondent's chart is dated December 2, 2017. It
15 listed no medications, merely stated, "continue meds." In a separate prescription (#5-2214), dated
16 December 2, 2017, Respondent prescribed alprazolam (120 with two refills) to Patient B. In
17 another separate prescription (#5-2212), dated December 2, 2017, Respondent prescribed
18 Elavil®, lorazepam, [and another illegible drug] to Patient B. In another separate prescription
19 (#5-2213), dated December 2, 2017, Respondent prescribed trazadone to Patient B.

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

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

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

1 trazodone, and Restoril® to Patient B. In another separate prescription (#6-1402), dated April 14,
2 2018, Respondent prescribed Neurontin®, Xanax®, and Elavil® to Patient B.

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

4 **FIRST CAUSE FOR DISCIPLINE**

5 **(Gross Negligence and Incompetence)**

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

10 **Patient A.**

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

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

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

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

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

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

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

5 E. Respondent failed to adequately re-assess Patient A, diagnose and formulate a
6 treatment plan at each visit with the patient, including listing of her current complaints, problems,
7 ongoing conditions, diagnoses, and plans, and/or document the same. Respondent initially
8 diagnosed Patient A with Anxiety Disorder NOS and depressive episodes at his first visit with
9 her. Later, on or about August 28, 2016, she complained of attention problems and Respondent
10 assessed her and diagnosed her with ADD. However, these problems are not listed in subsequent
11 visit notes, nor addressed with an assessment and plan for each visit. Without separate
12 assessments and plans for each problem, changes in treatment are not assigned to any problem.
13 For example, at her visit on or about March 11, 2017, Respondent changed her prescription from
14 Vyvanse® (lisdexamfetamine) to mixed amphetamine salts, but made no reference to her ADD as
15 a problem in the notes, and failed to adequately document any rationale for this change.
16 Additionally, his chart notes for patient visits on or about each of the following dates do not
17 address the status of, or treatment for, any of Patient A's prior diagnosed problems (e.g., anxiety,
18 ADD): August 28, 2016, December 31, 2016, March 11, 2017, July 2, 2017, and September 16,
19 2017.

20 Patient B.

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

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

1 in Patient B during the time he treated her and this represents incompetence. Respondent failed to
2 taper the patient off the benzodiazepine drugs he was prescribing. On or about May 19, 2014,
3 Respondent initially prescribed to Patient B, alprazolam (25 mg, three per day), but did not
4 indicate whether or not this would be a short-term treatment. Respondent increased the dose of
5 alprazolam over time as the patient developed tolerance, including as early as two weeks after her
6 initial visit. Her daily dosage of alprazolam increased on or about the following dates: January 9,
7 2016 (2.25 mg); January 16, 2016 (3.5 mg); March 14, 2016 (5 mg); June 26, 2016 (8 mg). This
8 far exceeds normal doses of alprazolam. The regimen creates a serious risk of seizures and
9 psychosis in case of interruption, without any therapeutic benefit. Moreover, on or about June 26,
10 2016, he wrote that even at the current high dose, the alprazolam was beginning to lose
11 effectiveness. Respondent failed to understand that while increasing the dose of a benzodiazepine
12 may give short-lived anti-anxiety effects, it quickly produces tolerance for the larger dose. In
13 addition, as the benzodiazepine wears off there is impending withdrawal. Respondent wrongly
14 believed that upward dose adjustments would treat anxiety. Respondent also prescribed
15 temazepam at higher than recommended dose levels and was warned about this repeatedly by
16 Express Scripts. Finally, he similarly prescribed to the patient clonazepam at a high dose.
17 Respondent failed to adequately advise the patient about the risks involved with his prescribing,
18 including the dangers of dependence, concomitant use of alcohol or pain medications, driving, or
19 risks of dependence and withdrawal, and fatal respiratory depression.

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

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

2 C. Respondent failed to understand the risks and lack of benefit of his prescribing
3 of multiple benzodiazepines to Patient B. There is no rationale for prescribing more than one
4 benzodiazepine to Patient B. There is no benefit to Respondent's multiple simultaneous
5 benzodiazepine prescribing to Patient B and that prescribing created increased risks. Combining
6 several benzodiazepines increases the risk of tolerance and dependence, with associated risk of
7 withdrawal, and does not convey any therapeutic benefit. Respondent regularly prescribed
8 alprazolam to Patient B, while she was at times, simultaneously taking at least one and often two
9 other benzodiazepines, including temazepam, oxazepam, clonazepam, and diazepam.

10 Respondent was asked at his Subject Interview about prescriptions for two benzodiazepines,
11 "Why both?" He replied, "Bipolar depression is difficult to deal with" - which demonstrated that
12 Respondent had no rationale for this practice and/or failed to appreciate the risks.

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

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

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

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

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

1 adequately monitor these concerns.

2 **SECOND CAUSE FOR DISCIPLINE**

3 **(Repeated Negligent Acts and Incompetence)**

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

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

9 **Patient A**

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

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

17 **Patient B**

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

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

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

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

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

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

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

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

18 Factual Allegations: Patient C

19 114. On or about April 16, 2013, Respondent first saw Patient C, a 46-year-old man with a
20 history of ADD and depression for 20 years. The patient's medication list included: Vyvanse®
21 (70 mg); Lexapro® (20 mg); Xanax® (1 mg); and AndroGel®. Respondent's diagnosis included,
22 "ADHD, major depression [illegible – DO?], recurrent non-psychotic." Respondent's plan was to
23 increase the patient's prescription for Lexapro® (to 30 mg per day), and to add prescriptions for
24 Adderall® XR (30 mg bid) and Abilify®.

25 115. Thereafter, Respondent continued to treat Patient C until at least in or around May 19,
26 2018. During this treatment period, the patient's medical records are replete with additional
27 communications from the patient regarding prescription requests, adjustments, and special
28 circumstances (i.e., prescriptions thrown away, confiscated or needed for travel). After his initial

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

5 116. At his Subject Interview, Respondent acknowledged that Patient C was an addict.
6 But, Respondent stated that he did not recognize that Patient C was an addict until the "last 12
7 months, six months, seven months, eight months [since March 21, 2019]." He stated that in the
8 beginning, the patient "needed something for his ADD," and depression. He further explained
9 that in the beginning, it looked like he had depression and anxiety as well, and he gave him
10 medications to treat those conditions. He also stated that the patient wrote him "all of these notes
11 because he wants me to be sure." He then explained that he was beginning to see that the patient
12 was dependent on prescription medications. However, he did cooperate with his requests, and at
13 his Subject Interview, Respondent stated that maybe he should have verified some of the patient's
14 special requests, e.g., when the patient wanted three pills for an airplane trip to New Mexico, he
15 should have asked to see a ticket. When asked about Patient C repeatedly losing his prescriptions
16 or that they were stolen from him or confiscated at the airport, Respondent "accepted some of
17 that," but did not remember the patient losing any prescriptions. Respondent also acknowledged
18 that he accommodated the patient's special prescription requests on or about March 25, 2014, to
19 obtain Adderall as a "separate 'script' [he] will fill it a few days later," followed by a letter
20 written on that same date, referring to the need for prescriptions to be written on that day due to
21 impending travel plans by the patient. Respondent also acknowledged a request by the patient to
22 change the date of an already post-dated prescription [which is essentially an illicit refill] for
23 Adderall⁹ in a letter dated July 17, 2014. They also discussed an email, dated August 20, 2014,
24 wherein Patient C proposed to follow Patient C's own treatment regimen to Respondent, and a
25 letter faxed on or about November 10, 2014, wherein Patient C apologized to Respondent for
26 "ever drawing the kind of federal (DEA) attention [to Respondent] and whereon he wrote by
27 hand, "I will call and make my payment as well." And, Respondent stated that Patient C was his

28 ⁹ Respondent admitted to this at his Subject Interview.

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

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

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

1 that Respondent prescribe this combination to him again.

2 **THIRD CAUSE FOR DISCIPLINE**

3 **(Incompetence)**

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

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

8 **FOURTH CAUSE FOR DISCIPLINE**

9 **(Record Keeping)**

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

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

16 **FIFTH CAUSE FOR DISCIPLINE**

17 **(Excessive Prescribing)**

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

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

22 **SIXTH CAUSE FOR DISCIPLINE**

23 **(Prescribing Without Appropriate Examination)**

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

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

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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.

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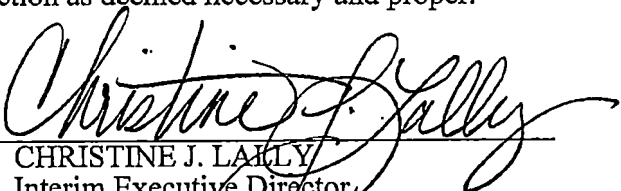
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PRAYER

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

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