ROB BONTA
Attorney General of California
GREGORY J. SALUTE
Supervising Deputy Attorney General
MICHAEL M. KARIMI
Deputy Attorney General
State Bar No. 260906
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9607
Facsimile: (619) 645-2061
E-mail: Michael.Karimi@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against: **TALAMI INTERNATIONAL, INC., DBA PALM CARE PHARMACY; USAMA ALKAZAKI, CEO/SECRETARY/CFO** **505 N. Mollison Avenue, Ste. 102** **El Cajon, CA 92021** **Pharmacy Permit No. PHY 53746,** **USAMA ALKAZAKI** **1724 Horizon Heights Circle** **El Cajon, CA 92019** **Pharmacist License No. RPH 69696,** **SARAH ADEL ABDULKAREEM KALA** **3911 Paseo Tamayo** **La Mesa, CA 91941** **Pharmacist License No. RPH 76476** **BRENDA OFELIA CORTEZ-GOMEZ** **1140 Chimney Flats Lane** **Chula Vista, CA 91915** **Pharmacist License No. RPH 67947** Respondents.	Case No. 7033 **FIRST AMENDED ACCUSATION**

In the Matter of the Statement of Issues Against: **TALAMI INTERNATIONAL HEALTH LLC, DBA PALM CARE PHARMACY** **Applicant for Pharmacy Permit** Respondent.	Case No. 7070 **FIRST AMENDED STATEMENT OF ISSUES**
In the Matter of the Statement of Issues Against: **DREAM BORDER VILLAGE, LLC, DBA PALM CARE PHARMACY 1005** **Applicant for Pharmacy Permit** Respondent.	Case No. 7432 **STATEMENT OF ISSUES**

PARTIES

1. Anne Sodergren (Complainant) brings this First Amended Accusation, First Amended Statement of Issues, and Statement of Issues, solely in her official capacity as the Executive Officer of the Board of Pharmacy, Department of Consumer Affairs (Board).

2. On or about August 14, 2015, the Board issued Pharmacy Permit Number PHY 53746 to Talami International, Inc., dba Palm Care Pharmacy (Respondent Palm Care). Usama Alkazaki (Respondent Alkazaki) has served, or been listed in Board records, as the sole shareholder and Chief Executive Officer of Talami International, Inc., and as the Pharmacist-in-Charge of Palm Care Pharmacy since the issuance of Pharmacy Permit Number PHY 53746. The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on August 1, 2024, unless renewed.

3. On or about September 5, 2013, the Board issued Pharmacist License Number RPH 69696 to Respondent Alkazaki. The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2025, unless renewed.

4. On or about May 24, 2017, the Board issued Pharmacist License Number RPH 76476 to Sarah Adel Abdulkareem Kala (Respondent Kala). Respondent Kala was a staff pharmacist at Palm Care. The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2024, unless renewed.

5. On or about August 29, 2012, the Board issued Pharmacist License Number RPH 67947 to Brenda Ofelia Cortez-Gomez (Respondent Cortez-Gomez). Respondent Cortez-Gomez was a staff pharmacist at Palm Care. The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2024, unless renewed.

6. On or about August 27, 2020, the Board received an application for a Community Pharmacy License from Talami International Health LLC, dba Palm Care Pharmacy. On or about August 12, 2020, Respondent Alkazaki certified under penalty of perjury to the truthfulness of all statements, answers, and representations in the application. The application identified Respondent Alkazaki as the Manager, CEO, sole owner of outstanding shares, and only member, manager, and officer of Talami International Health LLC. The Board denied the application on November 10, 2020.

7. On or about October 21, 2022, the Board received an application for a pharmacy permit from Dream border Village, LLC, dba Palm Care Pharmacy 1005. On or about December 6, 2022, Amjad A. Alqazqi certified under penalty of perjury to the truthfulness of all statements, answers, and representations in the application. The application identified Respondent Alkazaki's brother, Amjad A. Alqazqi, as the Managing Member and sole owner of the outstanding shares of Dream Border Village, LLC. The Board denied the application on December 6, 2022.

JURISDICTION

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

9. Section 4011 provides that the Board shall administer and enforce both the Pharmacy Law (Bus. & Prof. Code, § 4000 *et seq*.) and the Uniform Controlled Substances Act (Health & Safety Code, § 11000 *et seq*.).

10. Code section 4300 provides, in pertinent part, that every license issued by the Board is subject to discipline, including suspension or revocation.

11. Code section 4300 further provides, in pertinent part, that the Board may refuse a license to any applicant guilty of unprofessional conduct.

12. Code section 4300.1 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

13. Code section 4302 provides, in pertinent part, that the Board may deny, suspend, or revoke any license where conditions exist in relation to any person holding 10 percent or more of the ownership interest or where conditions exist in relation to any officer, director, or other person with management or control of the license that would constitute grounds for disciplinary action against a licensee.

14. Section 4307 of the Code states:

> (a) Any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under suspension, or who has been a manager, administrator, owner, member, officer, director, associate, partner, or any other person with management or control of any partnership, corporation, trust, firm, or association whose application for a license has been denied or revoked, is under suspension or has been placed on probation, and while acting as the manager, administrator, owner, member, officer, director, associate, partner, or any other person with management or control had knowledge of or knowingly participated in any conduct for which the license was denied, revoked, suspended, or placed on probation, shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee as follows:
>
> (1) Where a probationary license is issued or where an existing license is placed on probation, this prohibition shall remain in effect for a period not to exceed five years.
>
> (2) Where the license is denied or revoked, the prohibition shall continue until the license is issued or reinstated.

INTRODUCTION

15. Palm Care Pharmacy dispensed drugs to patients in a retail setting known as a community pharmacy. The pharmacy targets immigrants who are Arabic speaking in San Diego County with social media posts written in Arabic, and videos posted to social media spoken in Arabic. Palm Care represents that its staff has "a firsthand understanding of the challenges faced by those navigating healthcare in a new country." The pharmacy also describes itself as maintaining a "family atmosphere" where it knows and checks on its patients, wants to see them "healthy and happy" and will do "everything we can to assist with [their] wellbeing."

16. Despite professing to have the best interests of its vulnerable population of patients at

heart as if they were "family," Palm Care was actually engaging in a variety of insurance fraud schemes while simultaneously endangering patients by making repeated dispensing errors, and by dispensing adulterated drugs. When the Board initiated its investigations into Respondents' dispensing practices, Respondents Palm Care and its Pharmacist-in-Charge attempted to cover up their wrong-doing by altering pharmacy records and making false statements to the Board.

17. The Board's five investigations into Palm Care are identified in this pleading as the "Molina" and the "La Maestra" investigations (each involving multiple forms of fraud), the "La Mesa Cardiac Center" investigation (one form of fraud and a dispensing error), and the "patient M.A.", and "patient F.S." investigations (each involving prescription dispensing errors, but with patient F.S. also involving the alteration of records and the making of false statements to conceal the error).

18. The Molina investigation primarily involved providers at the Neighborhood Healthcare clinic and prescriptions billed to insurer Molina Healthcare. Palm Care was engaged in a scheme of falsifying insurance approval requests to obtain insurance payments for hundreds of prescription fills for the newer and higher cost medication Metformin ER *Gastric* (brand name Glumetza), rather than the older and lower cost medication Metformin ER (brand name Glucophage), even though it was only original Metformin ER that had actually been prescribed to the patients. In addition to this prescription fraud scheme, Respondent Alkazaki himself fraudulently billed 258 other medications to various insurers using the federally issued identifiers assigned to a Neighborhood Healthcare clinic nurse practitioner.

19. The La Maestra investigation arose through La Maestra Community Health Center providers. First, providers reported that Palm Care was forging prescription authorizations related to six patients: M.K., S.S., C.B., I.M., I.S., and K.B. Second, Palm Care's internally maintained *dispensing data* record showed the pharmacy was billing and dispensing drugs to patients at rates far in excess of the amount that had purportedly been authorized for a given period; in some instances at a rate more than triple the purported prescriber authorization. Third, Palm Care records had been intentionally altered on at least one occasion to conceal a dispensing error to a patient S.O., and there were a wide variety of other significant discrepancies in the

pharmacy's records related to the unauthorized prescriptions dispensed to M.K., S.S., C.B., I.M., I.S., and K.B. which indicated additional record alterations had been made.

20. Dispensing errors were also present in the other investigations. In the La Mesa Cardiac Center investigation, Palm Care dispensed a prescription for the drug furosemide incorrectly labeled as "blood thinner." Moreover, a review of Palm Care's internally maintained *dispensing data* record again revealed the pharmacy was billing and dispensing drugs to patients at rates far in excess of the amount that had purportedly been authorized for a given period, in one instances at a rate more than five times the purported authorization, and in two instances at more than two and a half times the purported authorization.

21. The patient M.A. investigation and the patient F.S. investigation each confirmed dispensing errors which caused harm to patients. In the case of patient M.A., the patient had been hospitalized after taking metoprolol which Palm Care mistakenly dispensed instead of the prescribed drug metformin. In the subsequent error, involving patient F.S., Palm Care had incorrectly labeled the blood thinner Eliquis with the words "for diabetes," causing the patient exacerbated bleeding from a stomach ulcer after he repeatedly took the blood thinner to try to control his blood sugar.

22. Critically, with patient F.S., Palm Care tried to cover-up the error. Namely, Palm Care's *dispensing data* for patient F.S. was altered to omit any record of the dispensing error by the time of the Board's investigation into the complaint. When Respondent Alkazaki provided the altered record to the Board investigator, he also provided a written statement asserting F.S. had been mistaken in his belief that Palm Care had incorrectly labeled the medication. However, the Eliquis prescription dispensed to F.S. with the erroneous "for diabetes" direction was found in a prior version of Palm Care's *dispensing data* that was produced when the patient M.A. complaint was investigated.

23. In sum, Respondents were regularly and opportunistically engaging in multiple forms of fraud to enrich themselves at the expense of insurers and taxpayers, while simultaneously disregarding and neglecting the well-being of vulnerable patients, at every step along the way actively attempting to conceal their actions under false veneers of care and innocence.

STATUTORY PROVISIONS

24. Section 550 of the Penal Code states, in pertinent part:

(a) It is unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do any of the following:

…

(5) Knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim.

(6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.

(7) Knowingly submit a claim for a health care benefit that was not used by, or on behalf of, the claimant.

…

25. Section 810 of the Code states, in pertinent part:

(a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his or her professional activities:

(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.

(2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or to allow it to be presented or used in support of any false or fraudulent claim.

(b) It shall constitute cause for revocation or suspension of a license or certificate for a health care professional to engage in any conduct prohibited under Section 1871.4 of the Insurance Code or Section 549 or 550 of the Penal Code.

…

26. Section 4022 of the Code states:

Dangerous drug or dangerous device means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: Caution: federal law prohibits dispensing without prescription, Rx only, or words of similar import.

(b) Any device that bears the statement: Caution: federal law restricts this device to sale by or on the order of a _____, Rx only, or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

27. Section 4059 of the Code states, in pertinent part, that a person may not furnish any dangerous drug except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7.

28. Section 4063 of the Code states, that no prescription for any dangerous drug or dangerous device may be refilled except upon authorization of the prescriber. The authorization may be given orally or at the time of giving the original prescription. No prescription for any dangerous drug that is a controlled substance may be designated refillable as needed.

29. Section 4077 of the Code states, in pertinent part:

> (a) Except as provided in subdivisions (b) and (c), no person shall dispense any dangerous drug upon prescription except in a container correctly labeled with the information required by Section 4076.
>
> …

30. Section 4076 of the Code states, in pertinent part:

> (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:
>
> …
>
> (2) The directions for the use of the drug.
>
> …

31. Section 4040 of the Code states, in pertinent part:

> (a) "Prescription" means an oral, written, or electronic transmission order that is both of the following:
>
> (1) Given individually for the person or persons for whom ordered that includes all of the following:
>
> …
>
> (B) The name and quantity of the drug or device prescribed and the directions for use.
>
> (C) The date of issue.
>
> …

32. Section 4071 of the Code states:

> Notwithstanding any other provision of law, a prescriber may authorize his or her agent on his or her behalf to orally or electronically transmit a prescription to the furnisher. The furnisher shall make a reasonable effort to determine that the person who transmits the prescription is authorized to do so and shall record the name of the

authorized agent of the prescriber who transmits the order.

33. Section 4324 subsection (a) of the Code states, in pertinent part, that every person who signs the name of another, or of a fictitious person, or falsely makes, alters, forges, utters, publishes, passes, or attempts to pass, as genuine, any prescription for any drugs is guilty of forgery.

34. Section 4333 of the Code states, in pertinent part, that all prescriptions filled by a pharmacy and all other records required by Section 4081 shall be maintained on the premises and available for inspection by authorized officers of the law for a period of at least three years. In cases where the pharmacy discontinues business, these records shall be maintained in a board-licensed facility for at least three years.

35. Section 4125 of the Code states, in pertinent part:

> (a) Every pharmacy shall establish a quality assurance program that shall, at a minimum, document medication errors attributable, in whole or in part, to the pharmacy or its personnel. The purpose of the quality assurance program shall be to assess errors that occur in the pharmacy in dispensing or furnishing prescription medications so that the pharmacy may take appropriate action to prevent a recurrence.
>
> (b) Records generated for and maintained as a component of a pharmacy's ongoing quality assurance program shall be considered peer review documents and not subject to discovery in any arbitration, civil, or other proceeding, except as provided hereafter. That privilege shall not prevent review of a pharmacy's quality assurance program and records maintained as part of that system by the board as necessary to protect the public health and safety or if fraud is alleged by a government agency with jurisdiction over the pharmacy. Nothing in this section shall be construed to prohibit a patient from accessing his or her own prescription records. Nothing in this section shall affect the discoverability of any records not solely generated for and maintained as a component of a pharmacy's ongoing quality assurance program.
>
> …

36. Code Section 4169, subdivision (a)(2) states:

> (a) A person or entity shall not do any of the following:
>
> …
>
> (2) Purchase, trade, sell, or transfer dangerous drugs or dangerous devices that the person knew or reasonably should have known were adulterated, as set forth in Article 2 (commencing with Section 111250) of Chapter 6 of Part 5 of Division 104 of the Health and Safety Code.

37. Section 4113 of the Code states, in pertinent part:

> …

(c) The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy.

…

38. Section 4301 of the Code states, in pertinent part:

The board shall take action against any holder of a license who is guilty of unprofessional conduct or whose license has been issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:

...

(f) The commission of any act involving moral turpitude, dishonesty, fraud, deceit, or corruption, whether the act is committed in the course of relations as a licensee or otherwise, and whether the act is a felony or misdemeanor or not.

(g) Knowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a state of facts.

…

(o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of this chapter or of the applicable federal and state laws and regulations governing pharmacy, including regulations established by the board or by any other state or federal regulatory agency.

(p) Actions or conduct that would have warranted denial of a license.

(q) Engaging in any conduct that subverts or attempts to subvert an investigation of the board.

…

39. Section 4306.5 of the Code states:

Unprofessional conduct for a pharmacist may include any of the following:

(a) Acts or omissions that involve, in whole or in part, the inappropriate exercise of his or her education, training, or experience as a pharmacist, whether or not the act or omission arises in the course of the practice of pharmacy or the ownership, management, administration, or operation of a pharmacy or other entity licensed by the board.

(b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services.

(c) Acts or omissions that involve, in whole or in part, the failure to consult appropriate patient, prescription, and other records pertaining to the performance of any pharmacy function.

(d) Acts or omissions that involve, in whole or in part, the failure to fully maintain and retain appropriate patient-specific information pertaining to the performance of any pharmacy function.

40. Section 111255 of the Health & Safety Code states that any drug or device is adulterated if it has been produced, prepared, packed, or held under conditions whereby it may have been contaminated with filth, or whereby it may have been rendered injurious to health.

41. Section 111295 of the Health & Safety Code states that it is unlawful for any person to manufacture, sell, deliver, hold, or offer for sale any drug or device that is adulterated.

REGULATORY PROVISIONS

42. Title 16, section 1711, of the California Code of Regulations states, in pertinent part:

(a) Each pharmacy shall establish or participate in an established quality assurance program which documents and assesses medication errors to determine cause and an appropriate response as part of a mission to improve the quality of pharmacy service and prevent errors.

...

(c) (1) Each quality assurance program shall be managed in accordance with written policies and procedures maintained in the pharmacy in an immediately retrievable form.

(2) When a pharmacist determines that a medication error has occurred, a pharmacist shall as soon as possible:

(A) Communicate to the patient or the patient's agent the fact that a medication error has occurred and the steps required to avoid injury or mitigate the error.

(B) Communicate to the prescriber the fact that a medication error has occurred.

…

(d) Each pharmacy shall use the findings of its quality assurance program to develop pharmacy systems and workflow processes designed to prevent medication errors. An investigation of each medication error shall commence as soon as is reasonably possible, but no later than 2 business days from the date the medication error is discovered. All medication errors discovered shall be subject to a quality assurance review.

(e) The primary purpose of the quality assurance review shall be to advance error prevention by analyzing, individually and collectively, investigative and other pertinent data collected in response to a medication error to assess the cause and any contributing factors such as system or process failures. A record of the quality assurance review shall be immediately retrievable in the pharmacy. The record shall contain at least the following:

(1) the date, location, and participants in the quality assurance review;

(2) the pertinent data and other information relating to the medication error(s) reviewed and documentation of any patient contact required by subdivision (c);

(3) the findings and determinations generated by the quality assurance review; and,

(4) recommend changes to pharmacy policy, procedure, systems, or processes, if any.

...

(f) The record of the quality assurance review, as provided in subdivision (e) shall be immediately retrievable in the pharmacy for at least one year from the date the record was created.

…

43. Title 16, section 1713, of the California Code of Regulations states, in pertinent part:

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

...

44. Title 16, section 1716, of the California Code of Regulations states, in pertinent part:

Pharmacists shall not deviate from the requirements of a prescription except upon the prior consent of the prescriber or to select the drug product in accordance with Section 4073 of the Business and Professions Code.

...

COST RECOVERY

45. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

46. At all times relevant herein, Respondent Alkazaki was the pharmacist-in-charge at Palm Care. At all times relevant herein, Respondent Kala was employed as a staff pharmacist at Palm Care. The Board's investigation revealed the following facts from its five investigations.

MOLINA INVESTIGATION

47. On or about November 11, 2020, the Board received complaints from Neighborhood Healthcare (NHC) that primarily concerned Palm Care falsifying multiple *insurance approval requests* and dispensing unauthorized prescriptions that were falsely attributed to providers at NHC's El Cajon clinic. Palm Care had also falsified insurance approval requests, and dispensed unauthorized prescriptions, related to non-NHC providers. The falsified insurance approval requests at issue, whether attributed to providers at NHC or elsewhere, were submitted to Molina Healthcare (Molina) for approval.

48. The high-cost diabetes medication Metformin ER Gastric (brand name Glumetza) was the subject of the majority of these falsified insurance approval requests. Metformin ER *Gastric*, a newer drug, may be dispensed in response to gastrointestinal side effects that arise from use of the original Metformin ER (brand name Glucophage). However, Metformin ER Gastric is generally more expensive than Metformin ER, at one point during the time of this investigation ranging approximately $4 to $50 per tablet, while the approximate cost of Metformin ER ranged $0.05 to $0.27 per tablet.

49. As part of its cost and utilization controls for certain high-cost prescription drugs, California's public health insurance program Medi-Cal requires that approval be secured from a patient's private insurer before coverage will apply under the program. The request for the insurer's approval, known as a *prior authorization* request, occurs on a form that documents for the insurer why the requested benefit is medically necessary. Prior authorization was required for Metformin ER Gastric at all times relevant herein, whereas prior authorization was not required for Metformin ER.

50. Molina is one of the private insurers that receives Medi-Cal funds and provides coverage under the program to the public, and was the insurer that reviewed and approved the fraudulent prior authorization requests for Metformin ER Gastric at issue in this case. Molina requires the prescriber to authorize the request, and at the end of the request form has a field for the prescriber to attest to the truth of the contents of the request by signature or electronic ID verification. If the requestor completing the form is different from the prescriber authorizing the

request, there is a field for the requestor to identify themselves on the first page of the form, in the same section where the prescriber's identifying information is provided. In addition, there is a section in the request form where the medical justification for the request must be described.

51. Molina performed an audit after it learned Palm Care was submitting prior authorizations and dispensing prescriptions for Metformin ER Gastric that had not been requested by the prescribers. Molina's audit of the period between May 17, 2019 to April 29, 2020 determined that an overpayment to Palm Care of $307,404.94 had occurred under the approval of 41 prior authorization requests, resulting in Metformin ER Gastric being dispensed more than 150 times. Molina notified Palm Care of its findings on or about December 18, 2020. Palm Care continued to dispense and bill Molina for Metformin ER Gastric beyond the audit period such that through the first seven months of 2020 Palm Care had dispensed the medication 278 times, whereas four local comparison pharmacies had each dispensed the medication less than 10 times.

52. Palm Care's fraud extended beyond the act, in these 41 instances, of submitting a prior authorization request without the prescriber's knowledge, for a medication unauthorized by the prescriber. Rather, the requests themselves contained false statements and were completed in a deceptive manner. Specifically, these prior authorization requests were completed in a way that made it appear that it was made by the prescriber. With many of the requests, there was no indication in the relevant field on the first page of the form that the requestor was different from the prescriber, while in many other instances a name or part of a name was written without an indication that the named individual had no affiliation with the prescriber. Similarly, the signature at the end of the form on the prescriber line failed to give any degree of notice that the requestor was a pharmacy acting on its own initiative.[1] Moreover the narrative provided on the form to justify the request furthered the deception, often through a purported summary of the patient's medical history and purported adverse reactions to regular Metformin, with further false and deceptive statements such as, "Doctor recommends to start new therapy with Metformin Er 500mg gastric," "Doctor switched him to Glumetza," and "Must stop Metformin & start

[1] On 37 of the 41 forms the signature was not legible, on one the signature line was left blank, and the three legible signatures did not otherwise identify the signer.

Glumetza."

53. The findings of Molina's audit were validated during the Board's investigation with a sampling of 12 of the original 41 prior authorization requests. The clinic and/or prescriber in those instances again confirmed that Metformin ER Gastric was unauthorized. Specifically, two NHC providers, Dr. N.J., and Dr. K.M., accounting for 5 of the 41 prior authorization patient requests, directly confirmed that they had neither authorized the Metformin ER Gastric prescriptions attributed to them by Palm Care, nor had authorized or made a prior authorization request in support of them. A third NHC provider, Dr. J.T., no longer worked at NHC at the time of the investigation, but her patient records did not include an authorization for Metformin ER Gastric for the patient at issue who was formerly under her care at NHC. A fourth NHC provider, Dr. J.H., had passed away, but his patient records did not include an authorization for Metformin ER Gastric for the patient at issue who was formerly under his care at NHC. Two non-NHC providers, unaffiliated with one another, Dr. F.J. and Dr. M.B., accounting for another 5 of the 41 prior authorization patient requests, similarly confirmed that they had neither authorized the Metformin ER Gastric prescriptions attributed to them by Palm Care, nor had made a prior authorization request in support of them. From this grouping of prior authorization patient requests, the corresponding unauthorized Metformin ER Gastric prescriptions dispensed to three of Dr. F.J.'s patients were dispensed by Respondent Cortez-Gomez under Rx # 321107, Rx # 281475, and Rx # 278600.

54. In 2022, while the Molina audit were being validated, Palm Care continued to dispense unauthorized Metformin ER Gastric, as evidenced by the contents of faxed refill request forms sent to Dr. F.J. showing that the unauthorized medication had recently been dispensed. Palm Care continued to fax such prescription refill requests for Metformin ER Gastric to Dr. F.J. even after she had expressly denied earlier refill requests for the drug and informed Palm Care that she would not authorize it in the future.

55. Patients were also seemingly being coached to report abdominal discomfort in order to justify the more expensive Metformin ER Gastric. After years of care having not mentioned adverse reactions to their medications, some of Dr. F.J.'s patient on Metformin ER were suddenly

mentioning abdominal pain. When she asked these patients clarifying questions, they were unable to further describe the nature of the complications they were reporting. This lead Dr. F.J. to suspect the patients were being coached to report abdominal pain. Similarly, in 2020, *after* NHC learned of an unauthorized prior authorization submittal for a patient of Dr. N.J., and notified Palm Care that only regular Metformin ER was authorized for that patient, the patient contacted NHC to inform the clinic that she was requesting the change to Metformin ER Gastric.

56. Palm Care was also using the National Provider Identifier (NPI) and Drug Enforcement Administration (DEA) number of an NHC provider, Nurse Practitioner S.C., to submit prescription billings to insurers without the provider's knowledge or authorization. NPI numbers are unique identifiers issued by the Centers for Medicare and Medicaid Services to health care providers, and are used in electronic health care transactions and communications, including on prescription billings. Insurers generally will not process a claim without an appropriate NPI number associated with the claim. DEA numbers are unique identifiers issued by the Drug Enforcement Administration to allow providers to write controlled substance prescriptions, which the DEA can then monitor. Respondent Alkazaki used the identifiers assigned to NHC Nurse Practitioner S.C. on approximately 282 prescriptions between January 1, 2020 and December 9, 2020. Approximately 24 of these prescriptions were recorded as having been cancelled, leaving the remaining 258 as completed and billed to a variety of insurers including Molina and Community Health.

57. Apart from the falsified Metformin ER Gastric prior authorizations, Palm Care falsified a prior authorization for a Tretinoin prescription issued by NHC provider Dr. S.S. In this instance the prescription itself was authorized, but the provider was not aware that Palm Care had submitted a prior authorization request, and the request generated by Palm Care justified the prior authorization request by falsely reporting to Molina that the patient had previously tried an alternate medication. Respondent Cortez-Gomez also dispensed three other unauthorized prescriptions to the patient of NHC provider Dr. J.T. under Rx # 306678, Rx # 285437, and Rx # 285438.

///

LA MAESTRA INVESTIGATION

58. Beginning on or about April 17, 2018, the Board received a series of complaints from La Maestra Community Health Center in El Cajon (La Maestra) about prescriptions filled at Palm Care being falsely reported as authorized by providers at La Maestra. Palm Care billed such false prescriptions to insurers, including Molina, Aetna PDP, and Community Health Group.

59. Palm Care sent repeated prescription authorization requests on printed forms to La Maestra, but then dispensed the prescription without the prescriber's authorization. In some instances, Palm Care continued to dispense medication even after La Maestra notified Palm Care it was dispensing an unauthorized prescription. La Maestra reported that these prescriptions were for medications which had either never been authorized, or had once been authorized for the patient, but the more recent refills had not been authorized. Frequently, as of August 2018, the patient who was the subject of the false prescription, had not even been seen as a patient at La Maestra for years. Palm Care falsely authorized prescriptions for at least six patients: M.K., S.S., C.B., I.M., I.S., and K.B.

60. La Maestra provided 12 of the printed request refill authorization forms it had received from Palm Care for these six patients. These refill requests were directed to La Maestra providers Dr. R.M. and Dr. W.R. Each form contains preprinted information, which includes what purports to be the most recent dispensing history for the prescription, a unique Rx # for the last authorization, the name of the prescriber that is the target of the request, and the date of the request. A space is available for the authorizing prescriber to date, indicate the number of refills authorized, if any, and sign above their pre-printed name. A new unique Rx # would be generated after a (purported) new prescription authorization was received. Thus, the Rx # preprinted on the request refill form would relate only to the most recent prior prescription authorization that had already been dispensed.

61. Respondent Alkazaki was asked to provide hard copies of the prescriber authorizations for these 12 false prescriptions, and in response he produced 12 of the pharmacy's request refill authorization forms. Eight of the 12 forms provided purported to reflect that refill authorization had been given by phone. The remaining four request refill authorization forms, i.e.

under Rx # 129545, Rx # 126233, and Rx # 136394 for patient K.B., and Rx # 79471 for patient M.K., appeared less like a record of a purported phone authorization, but instead had an apparent check mark on the signature line in two instances, and a wavy line in the other two.

62. Of the 12 printed request refill authorization forms Respondent Alkazaki provided, 6 had a "Rx #" which matched the number shown on the version of the form provided by La Maestra, while 6 had a non-matching Rx #, but matched the relevant patient and medication. Thus in the comparisons of the contents of the different versions of the forms which is given in paragraphs 66 through 72, below, different Rx #s sometimes appear.

63. In addition, despite that Palm Care had sent all 12 authorization requests to La Maestra, Palm Care's records ultimately attributed prescriber authorization for 4 of these 6 request refill authorization forms with a non-matching Rx # to the following providers who were not associated with La Maestra: Dr. L. R., Dr. H.A., and Dr. M.B. However, Dr. L. R. confirmed that the prescription authorizations referenced above and attributed to her within Palm Care's records for patients I.M. and I.S., were false. Dr. C.C. confirmed that based on a chart review, the prescription authorizations described above and attributed to Dr. H.A. at Family Health Centers of San Diego for patient K.B. were false.

64. Aside from the confirmation given by the various prescribers that the prescriptions attributed to them were unauthorized, a wide variety of discrepancies in Palm Care's records across three different sources confirmed that its dispensing records were altered. Namely, there are multiple discrepancies among (a) the dispensing history reported on the version of the request refill forms maintained by Palm Care, (b) the dispensing history reported on the version of the request refill forms sent to the La Maestra providers by Palm Care, and (c) Palm Care's internally maintained *dispensing data*, a record of all the pharmacy's dispensing activities, produced by Palm Care during the investigation in spreadsheet format. The content of these often inconsistent records are presented in paragraphs 66 through 72, below. These discrepancies, which reveal that dispensing records were altered, further confirm the fraudulent nature of the 12 prescriptions.

///

///

65. **Patients X and S.O.** Palm Care committed a dispensing error involving a patient S.O. The patient contacted Palm Care to report the error, and in response, a delivery driver had retrieved the drug, lexothyroxine, to return it to the pharmacy. A copy of the prescription label and accompanying register receipt from this error, which S.O. initially provided to Dr. R.M., showed S.O.'s name under prescription number 157230 for 30 tablets with another 60 on the prescription. Respondent Alkazaki's initials were on the label. The label and register receipt were dated 6/26/18. However, Palm Care's dispensing data did not reflect that lexothyroxine was dispensed to S.O. Rather the dispensing data recorded that prescription number 157230 was filled on August 15, 2018 for a different patient, who will be referred to here as Patient X.[2] The dispensing data had therefore been altered by Palm Care to omit the June 2018 dispensing error.

66. Palm Care's dispensing records for Patient X's prescription for levothyroxine reflect further record discrepancies, including a pattern of excessive furnishing of dangerous drugs in relation to the use rate purportedly authorized by the prescriber. This pattern of excessive furnishing of drugs in relation to the use rate purportedly authorized is found to varying degrees within the records applicable to other patients, and is presented through the dispensing history for those patients which appear in paragraphs 66 through 72, below. A summary of Patient X's dispensing history for levothyroxine is presented here, as follows:

a) Palm Care's dispensing data records show that Patient X was prescribed levothyroxine on October 24, 2016. Patient X was instructed to "take one tablet by mouth every day thyroid," but was issued 90 tablets as a 30-day supply. The fifth 90 tablet refill was filled on March 28, 2017, thus totaling 540 tablets dispensed in this 155 day period.

b) Palm Care's dispensing data records show that Patient X was again given the same prescription on February 27, 2017, before the date of the final refill given on the previous prescription. The February 27, 2017 prescription was first filled on April 23, 2017, and the fifth 90 tablet refill was filled 133 days later on September 3, 2017, which would accordingly total 540 tablets dispensed. Adding 30 days of use to this 133-day time span would result in Patient X receiving 3.31 tablets per day in this period while being instructed to take one tablet daily.

[2] This patient's actual initials are identical to another patient's initials already used above.

c) Palm Care's dispensing data records show that Patient X was again given the same prescription on May 18, 2017, which would have overlapped with the period of the previous 5 refills. The May 18, 2017 prescription was first filled on October 1, 2017, giving Patient X 90 tablets only 28 days since the last issuance of 90 tablets. The eighth 90 tablet refill was filled 212 days later on May 1, 2018, which would total 810 tablets dispensed. Adding 30 days to this 212-day time span would result in Patient X receiving 3.34 tablets per day in this period while still being instructed to take one tablet daily.

d) Palm Care's dispensing data records show that Patient X was again given the same prescription on May 28, 2018, on which date the prescription was first filled, giving Patient X 90 tablets only 27 days since the last issuance of 90 tablets. The second 90 tablet refill was filled 53 days later on July 20, 2018, which would total 270 tablets dispensed. Adding 30 days to this 53-day time span would result in Patient X receiving 3.25 tablets per day in this period.

e) Palm Care's dispensing data records show that Patient X was again prescribed levothyroxine on June 26, 2018. Patient X was still instructed to take one tablet daily, but this time was issued 30 tablets as a 30-day supply beginning August 15, 2018 under prescription number 157230. The sixth 30 tablet refill was filled 162 days later on January 24, 2019, which would total 210 tablets dispensed. Adding 30 days to this 162-day time span would result in Patient X receiving 1.09 tablets per day in this period.

f) In the course of the Board's investigation, Respondent Alkazaki was asked to provide the original prescription for Rx # 157230, as this was the number on the prescription label received by S.O., with S.O.'s name on the label. Respondent Alkazaki provided a printed copy of an electronic prescription for Patient X bearing Rx # 150186, accompanied by a backtag sticker for prescription number 157230. Rx # 150186 was recorded in Palm Care's dispensing data as the May 28, 2018 prescription to Patient X. The backtag sticker bearing number 157230 was recorded in Palm Care's dispensing data as the June 26, 2018 prescription also for Patient X, delivered on August 15, 2018. This June 26, 2018 electronic prescription authorized 90 tablets as a 30-day supply, without authorization for refills, and instructed the use of one tablet daily. As indicated above, Palm Care's dispensing data records the issuance of 30 tablets as a 30 day supply

under Rx # 157230 beginning August 15, 2018, but with 6 refills subsequently dispensed. The 210 tablets dispensed would thus be in excess of the quantity authorized on the face of the prescription. The label that had been delivered to S.O. under Rx # 157230 on June 26, 2018 had been for 30 tablets with another 60 on the prescription, which is likely the quantity intended by the June 26, 2018 electronic prescription for Patient X provided by Respondent Alkazaki given the "one tablet daily" instruction.

67. **Patient M.K.** Of the 12 false prescriptions identified by La Maestra, one was for M.K. As of August of 2018, M.K. had last been seen at La Maestra on October 19, 2015. Palm Care produced two refill request forms for the same medication, under Rx # 86267 and Rx # 79471.

a) **Oyster Shell Calcium.** Rx # 86267 and Rx # 79471 were for Oyster Shell Calcium 500 Mg, recorded as initially dispensed by Respondent Alkazaki, with multiple refills dispensed by Respondent Kala under Rx # 86267. As of August of 2018, La Maestra had last authorized this medication for M.K. on October 5, 2015, at which time 5 refills were authorized. The request form *obtained from Palm Care* during the Board investigation of the false prescription for Rx # 79471 indicated as follows:

///

///

///

///

///

///

///

///

///

///

///

///

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
8/30/17	8/30/17	60	6	
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
8/2/17	8/2/17	60	0	1

The request form *obtained from Palm Care* during the Board investigation of the false prescription for Rx # 86267 indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
3/13/18	3/13/18	60	6	
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Dispensed
8/30/17	2/11/18	420	6	7

The prescription history information in the form *obtained from La Maestra*, which accordingly lacked an indication the request was approved, was for Rx # 86267 and indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
4/9/18		60		
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
8/30/17	4/9/18	480	8	8

The prescription history information contained in Palm Care's *dispensing data* for this medication indicated as follows[3]:

///

[3] Rx Numbers which appear with an asterisk in this table, and corresponding tables below unless otherwise indicated, mark a prescription authorization not attributed to a provider at La Maestra as recorded in Palm Care's dispensing data.

Rx Num.	Date Written	Date Filled	Quantity	Refill Num.	Days Supply
207503*	2/5/2019	2/5/2019	60	0	30
130269	3/13/2018	10/12/2018	60	6	30
130269	3/13/2018	9/15/2018	60	5	30
130269	3/13/2018	8/20/2018	60	4	30
130269	3/13/2018	7/24/2018	60	3	30
130269	3/13/2018	6/27/2018	60	2	30
130269	3/13/2018	6/1/2018	60	1	30
130269	3/13/2018	5/6/2018	60	0	30
139512		4/17/2018	[Cancelled]		
86267	8/30/2017	4/9/2018	60	8	30
86267	8/30/2017	3/13/2018	60	7	30
86267	8/30/2017	2/11/2018	60	6	30
86267	8/30/2017	1/15/2018	60	5	30
86267	8/30/2017	12/19/2017	60	4	30
86267	8/30/2017	11/22/2017	60	3	30
86267	8/30/2017	10/25/2017	60	2	30
86267	8/30/2017	9/27/2017	60	1	30
86267	8/30/2017	8/30/2017	60	0	30
79471	8/2/2017	8/2/2017	60	0	30
45048	1/27/2017	7/5/2017	60	6	30
45048	1/27/2017	6/8/2017	60	5	30
45048	1/27/2017	5/13/2017	60	4	30
45048	1/27/2017	4/17/2017	60	3	30
45048	1/27/2017	3/21/2017	60	2	30
45048	1/27/2017	2/22/2017	60	1	30

///

///

///

///

b) **Additional Prescriptions.**[4] Additional prescriptions documented in Palm Care's dispensing data for M.K. and attributed to a provider at La Maestra in 2016 and 2017, despite the fact that M.K. had last been seen at La Maestra on October 19, 2015, were for Vitamin D 2,000 Unit, Lisinopril, and Hm Vitamin D3.

68. **Patient S.S.** From the 12 false prescriptions identified by La Maestra, one was for S.S. As of August of 2018, S.S. had last been seen at La Maestra on January 31, 2017. The Palm Care refill request form was for Rx # 115685:

a) **Simvastatin.** Rx # 115685 was for Simvastatin 20 Mg recorded as initially dispensed by Respondent Kala, with a refill dispensed by Respondent Alkazaki. La Maestra had last authorized this medication for S.S. on January 31, 2017 The request form *obtained from Palm Care* during the Board investigation of the false prescription indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
5/31/18	5/31/18	30	2	
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
1/10/18	5/5/18	90	2	3

The prescription history information in the form *obtained from La Maestra*, which accordingly lacked an indication the request was approved, indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
4/8/18		30		
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
1/10/18	4/8/18	30	2	1

///

[4] No request forms for these medications were secured during the Board's investigation.

The prescription history information contained in Palm Care's *dispensing data* for this medication indicated as follows:

Rx Num.	Date Written	Date Filled	Quantity	Refill Num.	Days Supply
151316	5/31/2018	9/16/2018	30	4	30
151316	5/31/2018	8/20/2018	30	3	30
151316	5/31/2018	7/24/2018	30	2	30
151316	5/31/2018	6/27/2018	30	1	30
151316	5/31/2018	5/31/2018	30	0	30
115685	1/10/2018	5/5/2018	30	2	30
115685	1/10/2018	4/8/2018	30	1	30
115685	1/10/2018	3/12/2018	30	0	30
71074	6/19/2017	1/10/2018	30	4	30
71074	6/19/2017	12/19/2017	30	3	30
71074	6/19/2017	8/9/2017	30	2	30
71074	6/19/2017	7/13/2017	30	1	30
71074	6/19/2017	6/19/2017	30	0	30
45452	1/31/2017	5/1/2017	30	3	30
45452	1/31/2017	4/3/2017	30	2	30
45452	1/31/2017	3/7/2017	30	1	30
45452	1/31/2017	1/31/2017	30	0	30

69. **Patient C.B.** From the 12 false prescriptions identified by La Maestra, one was for C.B. As of August of 2018, C.B. had last been seen at La Maestra on October 7, 2016. The Palm Care refill request form was for Rx # 30574:

a) **Levothyroxine.** Rx # 30574 was for Levothyroxine 50 Mcg recorded as initially dispensed by Respondent Kala, with a refill dispensed by Respondent Alkazaki. La Maestra had last authorized this medication for C.B. on May 20, 2017, at which time no refills were authorized. The request form *obtained from Palm Care* during the Board investigation of the false prescription indicated as follows:

///

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
10/12/17	10/12/12	30	6	
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
9/28/16	9/12/17	90	4	3

The prescription history information in the form *obtained from La Maestra*, which accordingly lacked an indication the request was approved, was for Rx # 96416 and indicated as follows:

Authorization/Request				
Date of Rqst	Date Appr.	Quantity	Refill Auth.	
4/19/18		30		
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
10/12/17	4/19/18	180	6	6

The prescription history information contained in Palm Care's *dispensing data* for this medication indicated as follows:

Rx Num.	Date Written	Date Filled	Quantity	Refill Num.	Days Supply
224608*	4/22/2019	6/4/2019	30	0	30
168581	8/13/2018	11/18/2018	30	3	30
168581	8/13/2018	10/22/2018	30	2	30
168581	8/13/2018	9/26/2018	30	1	30
168581	8/13/2018	8/31/2018	30	0	30
98515	10/21/2017	8/4/2018	30	3	30
98515	10/21/2017	7/9/2018	30	2	30
98515	10/21/2017	6/12/2018	30	1	30
98515	10/21/2017	5/16/2018	30	0	30
96416	10/12/2017	4/19/2018	30	6	30
96416	10/12/2017	3/23/2018	30	5	30
96416	10/12/2017	2/25/2018	30	4	30

96416	10/12/2017	1/30/2018	30	3	30
96416	10/12/2017	1/4/2018	30	2	30
96416	10/12/2017	12/5/2017	30	1	30
96416	10/12/2017	11/7/2017	30	0	30
65023	5/20/2017	10/12/2017	30	1	30
30574*	9/28/2016	9/12/2017	30	2	30
30574*	9/28/2016	8/10/2017	30	1	30
30574*	9/28/2016	7/12/2017	30	0	30
65023	5/20/2017	6/15/2017	30	0	30
64477	5/18/2017	5/18/2017	30	0	30
30476	9/27/2016	4/18/2017	30	6	30
30476	9/27/2016	3/14/2017	30	5	30
30476	9/27/2016	2/13/2017	30	4	30

b) **Additional Prescriptions.**[5] Additional prescriptions documented in Palm care's dispensing data for C.B. and attributed to a provider at La Maestra for 2017 and 2018, despite the fact that C.B. had last been seen at La Maestra on October 7, 2016, were for Vitamin D 2,000 Unit, Vitamin D2 1.25 Mg, Verapamil Er 180 Mg, Ventolin Hfa 90 Mcg, Tudorza Pressair 400 Mcg, Pravastatin Sodium 40 Mg, Omeprazole Dr 20 Mg, Metoprolol Succ Er 50 Mg, Gabapentin 300 Mg, Calcitrate 200 Mg, Atenolol 50 Mg, and Aspirin Ec 81 Mg.

70. **Patient I.M.** Of the 12 false prescriptions identified by La Maestra, 1 was for I.M. As of August of 2018, I.M. had last been seen at La Maestra on February 27, 2018. The Palm Care refill request form was for Rx # 118481:

a) **Trifluoperazin**e. Rx # 118481 was for Trifluoperazine 1 Mg recorded as initially dispensed by Respondent Alkazaki, with a refill dispensed by Respondent Kala. La Maestra had last authorized this medication for I.M. on December 7, 2016, at which time 2 refills were authorized. The request form *obtained from Palm Care* during the Board investigation of the false prescription indicated as follows:

///

[5] No request forms for these medications were secured during the Board's investigation.

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
5/10/18	5/10/18	60	0	
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
1/23/18	2/18/18	120	1	2

The prescription history information in the form *obtained from La Maestra*, which accordingly lacked an indication the request was approved, indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	Date of Request
4/11/18		60		
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
1/23/18	2/18/18	120	1	2

The prescription history information contained in Palm Care's *dispensing data* for this medication indicated as follows:

Rx Num.	Date Written	Date Filled	Quantity	Refill Num.	Days Supply
191695	11/20/2018	1/7/2019	30	0	30
146011	5/10/2018	5/10/2018	60	3	30
138141		4/11/2018	[Cancelled]		
138133		4/11/2018	[Cancelled]		
118481	1/23/2018	2/18/2018	60	0	30
118481	1/23/2018	1/23/2018	60	3	30
107599	12/2/2017	12/26/2017	60	2	30
107599	12/2/2017	12/2/2017	60	1	30
101563	11/3/2017	11/3/2017	60	0	30
54599	3/28/2017	9/9/2017	60	6	30
54599	3/28/2017	8/11/2017	60	5	30
54599	3/28/2017	7/19/2017	60	4	30

54599	3/28/2017	6/19/2017	60	3	30
54599	3/28/2017	5/23/2017	60	2	30
54599	3/28/2017	4/25/2017	60	1	30
54599	3/28/2017	3/28/2017	60	0	30
38344	12/7/2016	2/28/2017	60	1	30
38344	12/7/2016	2/1/2017	60	2	30
191598	11/20/2018	11/20/2018	60	1	30

b) **Additional Prescriptions.**[6] Additional prescriptions documented in Palm Care's dispensing data for I.M. and attributed to a provider at La Maestra on a date after February 27, 2018, which was when I.M. had last been seen at La Maestra, were for Vitamin D3, Lisinopril, Levothyroxine, Fish Oil Conc 1,000 Mg, Clopidogrel 75 Mg, and Vitamin B-12 1,000 Mcg.

71. **Patient I.S.** Of the 12 false prescriptions identified by La Maestra, four were for I.S. As of August of 2018, I.S. had last been seen at La Maestra on April 17, 2018. The Palm Care refill request forms were for Rx # 133150, Rx # 133149, Rx #133157, and Rx #133158:

a) **Mapap.** Rx # 133150 was for Mapap 325 mg recorded as initially dispensed by Respondent Kala. La Maestra had last authorized this medication for I.S. on October 15, 2016, at which time 3 refills were authorized. The request form *obtained from Palm Care* during the Board investigation of the false prescription indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
4/19/18	4/19/18	90	0	
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
3/23/18	3/23/18	90	0	1

///

///

[6] No request forms for this medication were secured during the Board's investigation.

The prescription history information in the form *obtained from La Maestra*, which accordingly lacked an indication the request was approved, was otherwise consistent with the above content. The prescription history information contained in Palm Care's *dispensing data* for this medication indicated as follows[7]:

Rx Num.	Date Written	Date Filled	Quantity	Refill Num.	Days Supply
140155	4/19/2018	4/19/2018	90	0	30
133150	3/23/2018	3/23/2018	90	0	30
84351*	8/22/2017	2/25/2018	90	7	30
84351*	8/22/2017	1/29/2018	90	6	30
84351*	8/22/2017	1/3/2018	90	5	30
84351*	8/22/2017	12/6/2017	90	4	30
84351*	8/22/2017	11/9/2017	90	3	30
84351*	8/22/2017	10/15/2017	90	2	30
84351*	8/22/2017	9/18/2017	90	1	30
84351*	8/22/2017	8/22/2017	90	0	30
48651*	2/20/2017	7/26/2017	90	6	30
48651*	2/20/2017	6/29/2017	90	5	30
48651*	2/20/2017	6/2/2017	90	4	30
48651*	2/20/2017	5/8/2017	90	3	30
48651*	2/20/2017	4/17/2017	90	2	30
48651*	2/20/2017	3/20/2017	90	1	30
48651*	2/20/2017	2/20/2017	90	0	30

b) **Vitamin B-12.** Rx # 133149 was for Vitamin B-12 1,000 MCG recorded as initially dispensed by Respondent Kala. La Maestra had last authorized this medication for I.S. on August 13, 2016, at which time 5 refills were authorized. The request form *obtained from Palm Care* during the Board investigation of the false prescription indicated as follows:

///

[7] For this table, Rx Numbers which appear with an asterisk indicate a prescription authorization that is both not attributed to a provider at La Maestra, and is attributed to Dr. L. Rouel by Palm Care's dispensing data.

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
4/19/18	4/19/18	60	0	
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
3/23/18	3/23/18	60	0	1

The prescription history information in the form *obtained from La Maestra*, which accordingly lacked an indication the request was approved, was otherwise consistent with the above content. The prescription history information contained in Palm Care's *dispensing data* for this medication indicated as follows[8]:

Rx Num.	Date Written	Date Filled	Quantity	Refill Num.	Days Supply
140154	4/19/2018	4/19/2018	60	0	30
133149	3/23/2018	3/23/2018	60	0	30
84348*	8/22/2017	2/25/2018	60	7	30
84348*	8/22/2017	1/29/2018	60	6	30
84348*	8/22/2017	1/3/2018	60	5	30
84348*	8/22/2017	12/6/2017	60	4	30
84348*	8/22/2017	11/9/2017	60	3	30
84348*	8/22/2017	10/15/2017	60	2	30
84348*	8/22/2017	9/18/2017	60	1	30
84348*	8/22/2017	8/22/2017	60	0	30
48649*	2/20/2017	7/26/2017	60	6	30
48649*	2/20/2017	6/29/2017	60	5	30
48649*	2/20/2017	6/2/2017	60	4	30
48649*	2/20/2017	5/8/2017	60	3	30
48649*	2/20/2017	4/17/2017	60	2	30
48649*	2/20/2017	3/20/2017	60	1	30
48649*	2/20/2017	2/20/2017	60	0	30

[8] For this table, Rx Numbers which appear with an asterisk indicate a prescription authorization that is both not attributed to a provider at La Maestra, and is attributed to Dr. L. Rouel.

c) **Meclizine.** Rx # 133157 was for Meclizine 25 MG recorded as initially dispensed by Respondent Kala. La Maestra had never authorized this medication for I.S. The request form *obtained from Palm Care* during the Board investigation of the false prescription indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
4/19/18	4/19/18	40	0	
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
3/23/18	3/23/18	40	0	1

The prescription history information in the form *obtained from La Maestra*, which accordingly lacked an indication the request was approved, was otherwise consistent with the above content. The prescription history information contained in Palm Care's *dispensing data* for this medication indicated as follows:

Rx Num.	Date Written	Date Filled	Quantity	Refill Num.	Days Supply
140151	4/19/2018	4/19/2018	40	0	30
133157	3/23/2018	3/23/2018	40	0	30
117881*	1/19/2018	2/25/2018	40	1	30
117881*	1/19/2018	1/19/2018	40	0	30

d) **Cyclobenzaprine.** Rx # 133158 was for Cyclobenzaprine 10 MG recorded as initially dispensed by Respondent Kala. La Maestra had last authorized this medication for I.S. on August 13, 2016, at which time 3 refills were authorized. The request form *obtained from Palm Care* during the Board investigation of the false prescription indicated as follows:

///

///

///

///

///

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
4/19/18	4/19/18	60	0	
History				
Date Written	Last Filled	Quantity	Refill Auth	Tines Disp.
3/23/18	3/23/18	60	0	1

The prescription history information in the form *obtained from La Maestra*, which accordingly lacked an indication the request was approved, was otherwise consistent with the above content. The prescription history information contained in Palm Care's *dispensing data* for this medication indicated as follows[9]:

Rx Num.	Date Written	Date Filled	Quantity	Refill Num.	Days Supply
140158	4/19/2018	4/19/2018	60	0	30
133158	3/23/2018	3/23/2018	60	0	30
108439*	12/6/2017	1/29/2018	60	2	30
108439*	12/6/2017	1/3/2018	60	1	30
108439*	12/6/2017	12/6/2017	60	0	30
102800*	11/9/2017	11/9/2017	60	0	30
62301*	5/8/2017	10/15/2017	60	6	30
62301*	5/8/2017	9/18/2017	60	5	30
62301*	5/8/2017	8/22/2017	60	4	30
62301*	5/8/2017	7/26/2017	60	3	30
62301*	5/8/2017	6/29/2017	60	2	30
62301*	5/8/2017	6/2/2017	60	1	30
62301*	5/8/2017	5/8/2017	60	0	30
34446*	11/3/2016	4/17/2017	60	6	30
34446*	11/3/2016	3/20/2017	60	5	30
34446*	11/3/2016	2/20/2017	60	4	30

[9] For this table, Rx Numbers which appear with an asterisk indicate a prescription authorization that is both not attributed to a provider at La Maestra, and is attributed to Dr. L. Rouel.

72. **Patient K.B.** From the 12 false prescriptions identified by La Maestra, four were for K.B. As of August of 2018, K.B. had last been seen at La Maestra on October 4, 2017. The Palm Care refill request forms were for Rx # 129545, Rx # 126232, Rx # 126233, and Rx # 136394:

a) **Nystop.** Rx # 129545 was for Nystop 100,000 units/gram recorded as initially dispensed by Respondent Kala. La Maestra had never authorized this medication for K.B. The request form *obtained from Palm Care* during the Board investigation of the false prescription indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
6/15/18	[illegible]	30	0	
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
3/9/18	5/21/18	90	2	3

The prescription history information in the form *obtained from La Maestra*, which accordingly lacked an indication the request was approved, was for Rx # 154976 and indicated as follows:

Authorization/Request				
Date of Rqst	Date Approved	Quantity	Refill Auth.	
7/30/18		30		
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
6/15/18	7/11/18	60	1	2

The prescription history information contained in Palm Care's *dispensing data* for this medication indicated as follows:

///

///

///

///

Rx Num.	Date Written	Date Filled	Quantity	Refill Num.	Days Supply
154976*	6/15/2018	7/11/2018	30	1	30
154976*	6/15/2018	6/15/2018	30	0	30
129545*	3/9/2018	5/21/2018	30	2	30
129545*	3/9/2018	4/22/2018	30	1	30
129545*	3/9/2018	3/26/2018	30	0	30

b) **Mirtazapine.** Rx # 126232 was for Mirtazapine 15mg recorded as initially dispensed by Respondent Kala. La Maestra had never authorized this medication for K.B. The request form *obtained from Palm Care* during the Board investigation of the false prescription indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
6/15/18	6/15/18	30	0	
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
2/26/18	5/21/18	120	3	4

The prescription history information in the form *obtained from La Maestra*, which accordingly lacked an indication the request was approved, was for Rx # 154979 and indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
8/7/18		30		
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
6/15/18	7/11/18	60	1	2

The prescription history information contained in Palm Care's *dispensing data* for this medication indicated as follows:

///

Rx Num.	Date Written	Date Filled	Quantity	Refill Num.	Days Supply
209763*	2/13/2019	1/28/2020	30	3	30
209763*	2/13/2019	1/2/2020	30	2	30
209763*	2/13/2019	12/5/2019	30	1	30
209763*	2/13/2019	11/8/2019	30	0	30
192628*	11/27/2018	10/13/2019	30	4	30
267384*		10/11/2019	[Cancelled]		
220896*	4/2/2019	9/17/2019	30	6	30
220896*	4/2/2019	8/21/2019	30	5	30
220896*	4/2/2019	7/25/2019	30	4	30
220896*	4/2/2019	6/28/2019	30	3	30
220896*	4/2/2019	6/2/2019	30	2	30
220896*	4/2/2019	4/30/2019	30	1	30
220896*	4/2/2019	4/2/2019	30	0	30
192628*	11/27/2018	3/8/2019	30	3	30
192628*	11/27/2018	2/8/2019	30	2	30
192628*	11/27/2018	12/24/2018	30	1	30
192628*	11/27/2018	11/27/2018	30	0	30
154979*	6/15/2018	10/17/2018	30	4	30
154979*	6/15/2018	9/20/2018	30	3	30
154979*	6/15/2018	8/27/2018	30	2	30
154979*	6/15/2018	7/11/2018	30	1	30
154979*	6/15/2018	6/15/2018	30	0	30
126232*	2/26/2018	5/21/2018	30	3	30
126232*	2/26/2018	4/22/2018	30	2	30
126232*	2/26/2018	3/26/2018	30	1	30
126232*	2/26/2018	2/26/2018	30	0	30

In addition, Dr. Cabreros confirmed that Rx # 154979, the authorization for which was attributed to Dr. Atallah at Family Health Centers of San Diego, was false.

///

c) **Prazosin.** Rx # 126233 was for Prazosin 1 mg recorded as initially dispensed by Respondent Kala. La Maestra had last authorized this medication for K.B on December 20, 2016, at which time 3 refills were authorized. The request form *obtained from Palm Care* during the Board investigation of the false prescription indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
6/15/18	6/15/18	30	0	
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
2/26/18	5/21/18	120	3	4

The prescription history information in the form *obtained from La Maestra*, which accordingly lacked an indication the request was approved, was for Rx # 154975 and indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
7/30/18		30		
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
6/15/18	7/11/18	60	1	2

The prescription history information contained in Palm Care's *dispensing data* for this medication indicated as follows:

Rx Num.	Date Written	Date Filled	Quantity	Refill Num.	Days Supply
209762*	2/13/2019	1/28/2020	30	2	30
209762*	2/13/2019	1/2/2020	30	1	30
209762*	2/13/2019	12/5/2019	30	0	30
192627*	11/27/2018	11/8/2019	30	4	30
267383*		10/11/2019	[Cancelled]		
220897*	4/2/2019	9/17/2019	30	6	30
220897*	4/2/2019	8/21/2019	30	5	30

220897*	4/2/2019	7/25/2019	30	4	30
220897*	4/2/2019	6/28/2019	30	3	30
220897*	4/2/2019	6/2/2019	30	2	30
220897*	4/2/2019	5/6/2019	30	1	30
220897*	4/2/2019	4/7/2019	30	0	30
192627*	11/27/2018	3/15/2019	30	3	30
192627*	11/27/2018	2/16/2019	30	2	30
192627*	11/27/2018	1/18/2019	30	1	30
192627*	11/27/2018	12/14/2018	30	0	30
154975*	6/15/2018	7/11/2018	30	1	30
154975*	6/15/2018	6/15/2018	30	0	30
126233*	2/26/2018	5/21/2018	30	3	30
126233*	2/26/2018	4/23/2018	30	2	30
126233*	2/26/2018	3/26/2018	30	1	30
126233*	2/26/2018	2/26/2018	30	0	30

In addition, Dr. Cabreros confirmed that Rx # 154975, the authorization for which was attributed to Dr. Atallah at Family Health Centers of San Diego, was false.

d) **Fluticasone.** Rx # 136394 was for Fluticasone 50 mcg recorded as initially dispensed by Respondent Kala. La Maestra had last authorized this medication for K.B. on September 26, 2017, at which time 1 refill was authorized. The request form *obtained from Palm Care* during the Board investigation of the false prescription indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
6/15/18	6/15/18	16	0	
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
4/4/18	5/19/18	32	1	2

The prescription history information in the form *obtained from La Maestra*, which accordingly lacked an indication the request was approved, was for Rx # 154978 and indicated as follows:

Authorization/Request				
Date of Request	Date Approved	Quantity	Refill Auth.	
7/30/18		16		
History				
Date Written	Last Filled	Quantity	Refill Auth.	Times Disp.
6/15/18	7/11/18	32	1	2

The prescription history information contained in Palm Care's *dispensing data* for this medication indicated as follows:

Rx Num.	Date Written	Date Filled	Quantity	Refill Num.	Days Supply
275071*	11/11/2019	1/28/2020	16	3	30
275071*	11/11/2019	1/2/2020	16	2	30
275071*	11/11/2019	12/5/2019	16	1	30
275071*	11/11/2019	11/11/2019	16	0	30
154978	6/15/2018	7/11/2018	16	1	30
154978	6/15/2018	6/15/2018	16	0	30
136394	4/4/2018	5/19/2018	16	1	30
136394	4/4/2018	4/22/2018	16	0	30
92644	9/26/2017	3/26/2018	16	1	30
92644	9/26/2017	9/26/2017	16	0	30

73. Palm Care's prescription delivery practices were also reviewed as part of the La Maestra investigation. The pharmacy had delivery vehicles on routes which regularly ended after the pharmacy closed with prescriptions still in the delivery vehicle at the end of the route. Those drugs were then left in the vehicle overnight outside the pharmacy until the pharmacist on duty the following morning brought them in. The delivery vehicles used by Palm Care to store undelivered prescriptions were not temperature controlled overnight and the environmental conditions were not monitored.

///

///

///

LA MESA CARDIAC CENTER INVESTIGATION

74. On or about November 20, 2018, the Board received a complaint from La Mesa Cardiac Center concerning prescriptions filled at Palm Care.

75. Palm Care's records reflect that Furosemide was given to patient N.Y. under Rx # 185096 on October 23, 2018, with instructions to take one tablet "every day blood thinner." Furosemide is not a blood thinner and was therefore incorrectly labeled. This incorrect label appears to have been copied from Rx # 185097 for Aspirin EC, also given to patient N.Y.

76. Palm Care's records reflect that Lisinopril was given to patient N.Y. under Rx # 185095 with instructions to take 2 tablets daily. The prescription was filled on October 23, 2018, and the fourth refill of 60 tablets was given on February 5, 2019. In total 300 tablets were given in this 105-day period. Palm Care provided a hard copy of the handwritten prescription which authorized a total of 120 tablets.

77. Palm Care's records reflect that Carvedilol was given to patient D.A. with instructions to take 2 tablets daily. Rx # 132916 was filled on April 18, 2018, and the sixth refill of 60 tablets was given on September 25, 2018. In total, 420 tablets were given in this 160-day period. Thus, Palm Care dispensed drugs far in excess of the amounts authorized by the prescriber.

78. Palm Care's records reflect that Cerovite Senior Multivitamin was dispensed to patient M.I., with instructions to take 1 tablet daily. Rx # 160109 was filled on July 9, 2018, and the second refill of 100 tablets was given on August 31, 2018. In total, 300 tablets were given in this 53-day period. Thus, Palm Care dispensed drugs far in excess of the amounts authorized by the prescriber.

79. Palm Care's dispensing data reflects that a new Cerovite Senior Multivitamin prescription was authorized on September 4, 2018, and was first issued to M.I. on September 26, 2018 under Rx # 173562, with the second 100 tablet refill given on November 18, 2018. In total, 300 tablets were given in this second 53-day period. Thus, Palm Care dispensed drugs far in excess of the amounts authorized by the prescriber. The written prescription for Rx # 173562, dispensed by Respondent Cortez-Gomez, was not dated except under a January 1, 2013 header.

PATIENT M.A. INVESTIGATION

80. On or about January 24, 2020, the Board received a complaint concerning Palm Care from a patient identified here by the initials M.A. M.A. reported that Palm Care had dispensed metoprolol to him on or about December 8, 2019 instead of metformin, and he was hospitalized as a result of Palm Care's error of dispensing the wrong medication. Metoprolol is indicated for use in the treatment of hypertension. Metformin is indicated for use in the treatment of diabetes.

81. In the course of the Board's investigation, Respondent Alkazaki was asked to provide documents related to patient M.A. Respondent Alkazaki provided an electronic prescription record for M.A. dated September 18, 2019 for Metformin with 12 additional refills authorized.

82. The dispensing record provided by Respondent Alkazaki shows Metformin 1,000 mg was dispensed on September 18, 2019 and refilled on October 15, 2019, under Rx # 261262. The dispensing record shows that under Rx # 261262 M.A. was then dispensed Metoprolol Tartrate 100 Mg on November 11, 2019 and again on December 8, 2019 with instructions to take "for the diabetes." Metoprolol is indicated for use in the treatment of hypertension and was therefore incorrectly labeled. The dispensing record shows that the two occasions under Rx # 261262 were the only record of Metoprolol being dispensed to M.A.

PATIENT F.S. INVESTIGATION

83. On or about October 27, 2020 the Board received a complaint concerning Palm Care from a patient identified here by the initials F.S. F.S. reported that Palm Care had been dispensed the blood thinner Eliquis incorrectly labeled with the instructions "for diabetes." F.S. reported that as a result of Palm Care's error, he took Eliquis every time his blood sugar was high, which caused excess bleeding and bruising, including exacerbating bleeding from a stomach ulcer. F.S. reported he only discovered Palm Care's error when he transferred to another pharmacy and the pharmacist there consulted him properly with accurate instructions on the Eliquis label.

84. In the course of the Board's investigation of a different complaint against Palm Care in February of 2020, Respondent Alkazaki provided Palm Care's dispensing data. The version of Palm Care's dispensing data provided at that time reflected that Respondent Alkazaki dispensed Eliquis under Rx # 266299 to F.S. on October 8, 2019 with directions to "Take one tablet by

mouth twice a day for diabetes." Based on this dispensing data, October 8, 2019 was the first date Eliquis had been dispensed to F.S. under Rx # 266299. This dispensing data provided by Palm Care further reflected that this transaction for Eliquis had been reversed from the insurance billing after it was filled. Palm Care's dispensing data also reflected that F.S. had separately been dispensed Eliquis under Rx # 258384 with directions to "Take one tablet by mouth twice daily blood thinner" on September 5, 2019, October 4, 2019, October 29, 2019, November 25, 2019, December 21, 2019, and January 17, 2020.

85. On or about December 16, 2020, in response to the Board's request for documents in connection with the F.S. Investigation, Respondent Alkazaki provided Palm Care's dispensing data for 2020, Palm Care's patient profile for F.S., and a copy of a backtag and prescription label bearing Rx # 266299. The backtag sticker showed a print date of December 10, 2020. The prescription label was dated June 25, 2020. The directions on each of these documents was to "Take one tablet by mouth twice a day blood thinner." Palm Care's 2020 dispensing data, and the patient profile for F.S. from 2018 through 2020, reflected that Eliquis had first been dispensed to F.S. under Rx # 266299 on February 13, 2020 with directions to "Take one tablet by mouth twice a day blood thinner." The October 8, 2019 Eliqiuis transaction under Rx # 266299 containing instructions to take "for diabetes" which exists in the dispensing data Palm Care provided in February 2020 was entirely omitted from the material Respondent Alkazaki provided in December 2020 in connection with the F.S. Investigation.

86. Respondent Alkazaki included a written statement concerning patient F.S. with the prescription records provided to the Board in December 2020. Respondent Alkazaki's written statement indicated F.S. had complained to Palm Care in April 2020 about his prescription under Rx # 266299 for Eliquis. Respondent Alkazaki's statement asserted that at the time F.S. had, "mistakenly believed that the Eliquis 5mg prescription he got from the Palm Care Pharmacy a few days prior was for diabetes and insisted that we gave him the wrong prescription." There was no mention of the October 8, 2019 transaction for Eliquis, which once existed under Rx # 266299, directing its use "for diabetes" in Respondent Alkazaki's written statement.

///

FIRST CAUSE FOR DISCIPLINE

(Acts Involving Dishonesty, Fraud or Deceit – Molina Investigation – Respondent Palm Care & Respondent Alkazaki)

87. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (f), for falsifying prior authorization requests, for falsifying, dispensing and billing unauthorized Metformin ER Gastric prescriptions, and for submitting prescription billings under nurse practitioner S.C.'s federally issued identifiers without authorization, described in the paragraphs above and incorporated herein as though set forth in full.

SECOND CAUSE FOR DISCIPLINE

(Making or Signing Document that Falsely Represents – Molina Investigation – Respondent Palm Care & Respondent Alkazaki)

88. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (g), for falsifying prior authorization requests, for falsifying, dispensing and billing unauthorized Metformin ER Gastric prescriptions, and for submitting prescription billings under nurse practitioner S.C.'s federally issued identifiers without authorization, described in the paragraphs above and incorporated herein as though set forth in full.

THIRD CAUSE FOR DISCIPLINE

(Insurance Fraud – Molina Investigation – Respondent Palm Care & Respondent Alkazaki)

89. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating Code section 810 by knowingly preparing, making or subscribing a writing with the intent to have it used in support of a false or fraudulent claim or knowingly making or causing to be made a false or fraudulent claim, or submitting a fraudulent claim for a health care benefit in violation of section 550 (a) of the Penal Code with respect to the falsified prior authorization requests, falsified Metformin ER Gastric prescriptions, and the prescriptions billed under nurse practitioner S.C.'s federally issued identifiers without authorization, described in the paragraphs above and incorporated herein as though set forth in full.

///

FOURTH CAUSE FOR DISCIPLINE

(Unauthorized Prescriptions – Molina Investigation – Respondent Palm Care & Respondent Alkazaki)

90. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating, for Code sections 4059 and 4063, and section 1716 of Title 16 of the California Code of Regulations by dispensing and billing unauthorized Metformin ER Gastric prescriptions, described in the paragraphs above and incorporated herein as though set forth in full.

FIFTH CAUSE FOR DISCIPLINE

(Forgery – Molina Investigation – Respondent Palm Care & Respondent Alkazaki)

91. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating Code section 4324, subdivision (a), for forging prior authorization requests and Metformin ER Gastric prescriptions, described in the paragraphs above and incorporated herein as though set forth in full.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Molina Investigation – Respondent Palm Care & Respondent Alkazaki)

92. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301 for unprofessional conduct for falsifying prior authorization requests, for falsifying, dispensing and billing unauthorized Metformin ER Gastric prescriptions, and for submitting prescription billings under nurse practitioner S.C.'s federally issued identifiers without authorization, described in the paragraphs above and incorporated herein as though set forth in full.

///

///

///

///

///

SEVENTH CAUSE FOR DISCIPLINE

(Acts Involving Dishonesty, Fraud or Deceit – La Maestra Investigation – Respondent Palm Care & Respondent Alkazaki)

93. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (f), for falsifying, dispensing and billing unauthorized prescriptions with respect to patients M.K., S.S., C.B., I.M., I.S., and K.B, for excessively furnishing drugs to patients in relation to the use rate authorized, and billing insurers, with respect to patients M.K., S.S., C.B., I.M., I.S., K.B., and X, and for creating and producing manipulated pharmacy records in connection with an investigation of the Board into the 12 request refill authorization forms identified above and into Rx # 157230, described in the paragraphs above and incorporated herein as though set forth in full.

EIGHTH CAUSE FOR DISCIPLINE

(Making or Signing Document that Falsely Represents – La Maestra Investigation – Respondent Palm Care & Respondent Alkazaki)

94. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (g), for falsifying, dispensing and billing unauthorized prescriptions with respect to patients M.K., S.S., C.B., I.M., I.S., and K.B., and for creating and producing manipulated pharmacy records in connection with an investigation of the Board into the 12 request refill authorization forms identified above and into Rx # 157230, described in the paragraphs above and incorporated herein as though set forth in full.

NINTH CAUSE FOR DISCIPLINE

(Insurance Fraud – La Maestra Investigation – Respondent Palm Care & Respondent Alkazaki)

95. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating Code section 810 by knowingly preparing, making or subscribing a writing with the intent to have it used in support of a false or fraudulent claim or knowingly making or causing to be made a false or fraudulent claim, or submitting a fraudulent claim for a health care benefit in violation of section 550 (a) of the Penal Code with

respect to the falsified prescriptions for patients M.K., S.S., C.B., I.M., I.S., and K.B., and the drugs furnished in excess of the use rate authorized to patients M.K., S.S., C.B., I.M., I.S., K.B, and X, described in the paragraphs above and incorporated herein as though set forth in full.

TENTH CAUSE FOR DISCIPLINE

(Unauthorized Prescriptions – La Maestra Investigation – Respondent Palm Care & Respondent Alkazaki)

96. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating, for Code sections 4059 and 4063, and section 1716 of Title 16 of the California Code of Regulations by dispensing and billing unauthorized prescriptions with respect to patients M.K., S.S., C.B., I.M., I.S., and K.B., and excessively furnishing drugs to patients in relation to the use rate authorized, and billing insurers, with respect to patients M.K., S.S., C.B., I.M., I.S., K.B, and X, described in the paragraphs above and incorporated herein as though set forth in full.

ELEVENTH CAUSE FOR DISCIPLINE

(Forgery – La Maestra Investigation – Respondent Palm Care & Respondent Alkazaki)

97. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating Code section 4324, subdivision (a), for forging prescriptions with respect to patients M.K., S.S., C.B., I.M., I.S., and K.B., described in the paragraphs above and incorporated herein as though set forth in full.

TWELFTH CAUSE FOR DISCIPLINE

(Subvert or Attempt to Subvert an Investigation – La Maestra Investigation – Respondent Palm Care & Respondent Alkazaki)

98. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (q), for subverting or attempting to subvert an investigation of the Board by creating and producing manipulated pharmacy records in connection with an investigation of the Board into the 12 request refill authorization forms identified above and into Rx # 157230, described in the paragraphs above and incorporated herein as though set forth in full.

THIRTEENTH CAUSE FOR DISCIPLINE

(Incorrect Labeling – La Maestra Investigation – Respondent Palm Care & Respondent Alkazaki)

99. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating Code sections 4077(a) and 4076(a)(3), for furnishing dangerous drugs with the incorrect patient name under Rx # 157230, described in the paragraphs above and incorporated herein as though set forth in full.

FOURTEENTH CAUSE FOR DISCIPLINE

(Adulterated Drugs – La Maestra Investigation – Respondent Palm Care & Respondent Alkazaki)

100. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating Health & Safety Code section 111295 and 4169, subdivision (a)(2) for holding and offering for sale drugs that were adulterated within the meaning of Health and Safety Code section 111255, described in the paragraphs above and incorporated herein as though set forth in full.

FIFTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – La Maestra Investigation – Respondent Palm Care & Respondent Alkazaki)

101. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301 for unprofessional conduct for falsifying, dispensing and billing unauthorized prescriptions with respect to patients M.K., S.S., C.B., I.M., I.S., and K.B, for excessively furnishing drugs to patients in relation to the use rate authorized, and billing insurers, with respect to patients M.K., S.S., C.B., I.M., I.S., K.B., and X, for creating and producing manipulated pharmacy records in connection with an investigation of the Board into the 12 request refill authorization forms identified above and into Rx # 157230, for furnishing dangerous drugs with the incorrect patient name under Rx # 157230, and for holding and offering for sale drugs that were adulterated, described in the paragraphs above and incorporated herein as though set forth in full.

SIXTEENTH CAUSE FOR DISCIPLINE

(Acts Involving Dishonesty, Fraud or Deceit – La Mesa Cardiac Investigation – Respondent Palm Care & Respondent Alkazaki)

102. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (f), for excessively furnishing drugs to patients in relation to the use rate authorized, and billing insurers, with respect to patients N.Y., D.A., and M.I., described in the paragraphs above and incorporated herein as though set forth in full.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Insurance Fraud – La Mesa Cardiac Investigation – Respondent Palm Care & Respondent Alkazaki)

103. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating Code section 810 by knowingly preparing, making or subscribing a writing with the intent to have it used in support of a false or fraudulent claim or knowingly making or causing to be made a false or fraudulent claim, or submitting a fraudulent claim for a health care benefit in violation of section 550 (a) of the Penal Code with respect to the drugs furnished in excess of the use rate authorized to patients N.Y., D.A., M.I., described in the paragraphs above and incorporated herein as though set forth in full.

EIGHTEENTH CAUSE FOR DISCIPLINE

(Unauthorized Prescriptions – La Mesa Cardiac Investigation – Respondent Palm Care & Respondent Alkazaki)

104. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating, for Code sections 4059 and 4063, and section 1716 of Title 16 of the California Code of Regulations by excessively furnishing drugs to patients in relation to the use rate authorized, and billing insurers, with respect to patients N.Y., D.A., and M.I., described in the paragraphs above and incorporated herein as though set forth in full.

///

///

NINETEENTH CAUSE FOR DISCIPLINE

(Incorrect Labeling – La Mesa Cardiac Investigation – Respondent Palm Care & Respondent Alkazaki)

105. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating Code sections 4077(a) and 4076(a)(2) and/or (a)(10), for furnishing dangerous drugs with incorrect directions for use and an incorrect description of the condition or purpose for which the drug was prescribed under Rx # 185096, described in the paragraphs above and incorporated herein as though set forth in full.

TWENTIETH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – La Mesa Cardiac Investigation – Respondent Palm Care & Respondent Alkazaki)

106. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301 for unprofessional conduct for excessively furnishing drugs to patients in relation to the use rate authorized, and billing insurers, with respect to patients N.Y., D.A., and M.I., and for furnishing dangerous drugs with incorrect directions for use and an incorrect description of the condition or purpose for which the drug was prescribed under Rx # 185096, described in the paragraphs above and incorporated herein as though set forth in full.

TWENTY-FIRST CAUSE FOR DISCIPLINE

(Incorrect Labeling – Patient M.A. Investigation – Respondent Palm Care & Respondent Alkazaki)

107. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating Code sections 4077(a) and 4076(a)(2) and/or (a)(10), for furnishing dangerous drugs with incorrect directions for use and an incorrect description of the condition or purpose for which the drug was prescribed under Rx # 261262, described in the paragraphs above and incorporated herein as though set forth in full.

///

///

///

TWENTY-SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Patient M.A. Investigation – Respondent Palm Care & Respondent Alkazaki)

108. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301 for unprofessional conduct for furnishing dangerous drugs with incorrect directions for use and an incorrect description of the condition or purpose for which the drug was prescribed under Rx # 261262, described in the paragraphs above and incorporated herein as though set forth in full.

TWENTY-THIRD CAUSE FOR DISCIPLINE

(Acts Involving Dishonesty, Fraud or Deceit – Patient F.S. Investigation – Respondent Palm Care & Respondent Alkazaki)

109. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (f), for creating and producing manipulated pharmacy records in connection with an investigation of the Board into Rx # 266299, described in the paragraphs above and incorporated herein as though set forth in full.

TWENTY-FOURTH CAUSE FOR DISCIPLINE

(Making or Signing Document that Falsely Represents – Patient F.S. Investigation – Respondent Palm Care & Respondent Alkazaki)

110. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (g), for creating and producing manipulated pharmacy records in connection with an investigation of the Board into Rx # 266299, described in the paragraphs above and incorporated herein as though set forth in full.

///

///

///

///

///

///

TWENTY-FIFTH CAUSE FOR DISCIPLINE

(Incorrect Labeling – Patient F.S. Investigation – Respondent Palm Care & Respondent Alkazaki)

111. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating Code sections 4077(a) and 4076(a)(2) and/or (a)(10), for furnishing dangerous drugs with incorrect directions for use and an incorrect description of the condition or purpose for which the drug was prescribed under Rx # 266299, described in the paragraphs above and incorporated herein as though set forth in full.

TWENTY-SIXTH CAUSE FOR DISCIPLINE

(Subvert or Attempt to Subvert an Investigation – Patient F.S. Investigation – Respondent Palm Care & Respondent Alkazaki)

112. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301, subdivision (q), for subverting or attempting to subvert an investigation of the Board by creating and producing manipulated pharmacy records in connection with an investigation of the Board into Rx # 266299, described in the paragraphs above and incorporated herein as though set forth in full.

TWENTY-SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Patient F.S. Investigation – Respondent Palm Care & Respondent Alkazaki)

113. Respondents Palm Care and Alkazaki are subject to disciplinary action under Code section 4301 for unprofessional conduct for creating and producing manipulated pharmacy records in connection with an investigation of the Board into Rx # 266299, and for furnishing dangerous drugs with incorrect directions for use and an incorrect description of the condition or purpose for which the drug was prescribed under Rx # 266299, described in the paragraphs above and incorporated herein as though set forth in full.

///

///

///

TWENTY-EIGHTH CAUSE FOR DISCIPLINE

(Acts Involving Dishonesty, Fraud or Deceit – La Maestra Investigation – Respondent Kala)

114. Respondent Kala is subject to disciplinary action under Code section 4301, subdivision (f), for falsifying, dispensing and billing unauthorized prescriptions with respect to patients M.K., S.S., C.B., I.M., I.S., and K.B., and for excessively furnishing drugs to patients in relation to the use rate authorized, and billing insurers, with respect to patients M.K., S.S., C.B., I.M., I.S., K.B., and X, described in the paragraphs above and incorporated herein as though set forth in full.

TWENTY-NINTH CAUSE FOR DISCIPLINE

(Making or Signing Document that Falsely Represents – La Maestra Investigation – Respondent Kala)

115. Respondent Kala is subject to disciplinary action under Code section 4301, subdivision (g), for falsifying, dispensing and billing unauthorized prescriptions with respect to patients M.K., S.S., C.B., I.M., I.S., and K.B., described in the paragraphs above and incorporated herein as though set forth in full.

THIRTIETH CAUSE FOR DISCIPLINE

(Insurance Fraud – La Maestra Investigation – Respondent Kala)

116. Respondent Kala is subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating Code section 810 by knowingly preparing, making or subscribing a writing with the intent to have it used in support of a false or fraudulent claim or knowingly making or causing to be made a false or fraudulent claim, or submitting a fraudulent claim for a health care benefit in violation of section 550 (a) of the Penal Code with respect to the falsified prescriptions for patients M.K., S.S., C.B., I.M., I.S., and K.B., and the drugs furnished in excess of the use rate authorized to patients M.K., S.S., C.B., I.M., I.S., K.B, and X, described in the paragraphs above and incorporated herein as though set forth in full.

///

///

///

THIRTY-FIRST CAUSE FOR DISCIPLINE

(Unauthorized Prescriptions – La Maestra Investigation – Respondent Kala)

117. Respondent Kala is subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating, for Code sections 4059 and 4063, and section 1716 of Title 16 of the California Code of Regulations by dispensing and billing unauthorized prescriptions with respect to patients M.K., S.S., C.B., I.M., I.S., and K.B., and excessively furnishing drugs to patients in relation to the use rate authorized, billed to insurers, with respect to patients M.K., S.S., C.B., I.M., I.S., K.B, and X, described in the paragraphs above and incorporated herein as though set forth in full.

THIRTY-SECOND CAUSE FOR DISCIPLINE

(Forgery – La Maestra Investigation – Respondent Kala)

118. Respondent Kala is subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating Code section 4324, subdivision (a), for forging prescriptions with respect to patients M.K., S.S., C.B., I.M., I.S., and K.B., described in the paragraphs above and incorporated herein as though set forth in full.

THIRTY-THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – La Maestra Investigation – Respondent Kala)

119. Respondent Kala is subject to disciplinary action under Code section 4301 for unprofessional conduct for falsifying, dispensing and billing unauthorized prescriptions with respect to patients M.K., S.S., C.B., I.M., I.S., and K.B, and for excessively furnishing drugs to patients in relation to the use rate authorized, billed to insurers, with respect to patients M.K., S.S., C.B., I.M., I.S., K.B., and X, described in the paragraphs above and incorporated herein as though set forth in full.

///

///

///

///

///

THIRTY-FOURTH CAUSE FOR DISCIPLINE

(Unauthorized Prescriptions – Molina Investigation – Respondent Cortez-Gomez)

120. Respondent Cortez-Gomez is subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating, for Code sections 4059 and 4063, and section 1716 of Title 16 of the California Code of Regulations by dispensing and billing unauthorized prescriptions with respect to Rx # 321107, Rx # 281475, Rx # 278600, Rx # 306678, Rx # 285437, and Rx # 285438, described in the paragraphs above and incorporated herein as though set forth in full.

THIRTY-FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Molina Investigation – Respondent Cortez-Gomez)

121. Respondent Cortez-Gomez is subject to disciplinary action under Code section 4301 for unprofessional conduct for dispensing and billing unauthorized prescriptions with respect to Rx # 321107, Rx # 281475, Rx # 278600, Rx # 306678, Rx # 285437, and Rx # 285438, described in the paragraphs above and incorporated herein as though set forth in full

THIRTY-SIXTH CAUSE FOR DISCIPLINE

(Uncertain Prescription – La Mesa Cardiac Investigation – Respondent Cortez-Gomez)

122. Respondent Cortez-Gomez is subject to disciplinary action under Code section 4301, subdivision (j) and/or (o), for violating, for Code section 4040(a)(1)(C), and section 1761 of Title 16 of the California Code of Regulations for dispensing a prescription which contained a significant error, omission, irregularity, uncertainty, or ambiguity, with respect to Rx # 173562, described in the paragraphs above and incorporated herein as though set forth in full.

THIRTY-SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – La Mesa Cardiac Investigation – Respondent Cortez-Gomez)

123. Respondent Cortez-Gomez is subject to disciplinary action under Code section 4301 for unprofessional conduct for dispensing a prescription which contained a significant error, omission, irregularity, uncertainty, or ambiguity, with respect to Rx # 173562, described in the paragraphs above and incorporated herein as though set forth in full.

///

OTHER MATTERS

124. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit No. PHY 53746 issued to Talami International, Inc., dba Palm Care Pharmacy, then Talami International, Inc. shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any position with management or control of a license for five years if Pharmacy Permit Number PHY 53746 is placed on probation or until Pharmacy Permit Number 53746 is reinstated if it is revoked.

125. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit No. PHY 53746 issued to Talami International, Inc., dba Total Care Pharmacy, and Usama Alkazaki had knowledge of, or knowingly participated in, the conduct for which the license is disciplined, then Usama Alkazaki shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any position with management or control of a license for five years if Pharmacy Permit Number PHY 53746 is placed on probation or until Pharmacy Permit Number 53746 is reinstated if it is revoked.

126. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit No. PHY 53746 issued to Talami International, Inc., dba Total Care Pharmacy, and Sarah Adel Abdulkareem Kala had knowledge of, or knowingly participated in, the conduct for which the license is disciplined, then Sarah Adel Abdulkareen Kala shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any position with management or control of a license for five years if Pharmacy Permit Number PHY 53746 is placed on probation or until Pharmacy Permit Number 53746 is reinstated if it is revoked.

127. Pursuant to Code section 4307, if discipline is imposed on Pharmacist License No. RPH 69696 issued to Usama Alkazaki, then Usama Alkazaki shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any position with management or control of a license for five years if Pharmacist License No. RPH 69696 is placed on probation or until Pharmacy Permit Number 69696 is reinstated if it is revoked.

128. Pursuant to Code section 4307, if discipline is imposed on Pharmacist License No. RPH 76476 issued to Sarah Adel Abdulkareem Kala, then Sarah Adel Abdulkareen Kala shall be

prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any position with management or control of a license for five years if Pharmacist License No. RPH 76476 is placed on probation or until Pharmacy Permit Number 67046 is reinstated if it is revoked.

DISCIPLINE CONSIDERATIONS

129. To determine the degree of discipline, if any, to be imposed on Respondent Talami International, Inc., dba Palm Care Pharmacy, Complainant alleges that on or about December 4, 2018, in a prior action, the Board of Pharmacy issued Citation Number CI 2016 74625 for violating section 1746.1, subsection (b)(4), of Title 16 of the California Code of Regulations, protocol for furnishing self-administered hormonal contraception. That Citation is now final.

130. To determine the degree of discipline, if any, to be imposed on Respondent Usama Alkazaki, Complainant alleges that on or about February 4, 2018, in a prior action, the Board of Pharmacy issued Citation Number CI 2018 82126 for violating section 1746.1, subsection (b)(4), of Title 16 of the California Code of Regulations, protocol for furnishing self-administered hormonal contraception. That Citation is now final.

///

///

///

///

///

///

///

///

///

///

///

///

///

FIRST AMENDED STATEMENT OF ISSUES AGAINST:

TALAMI INTERNATIONAL HEALTH, LLC, DBA PALM CARE PHARMACY

CAUSES FOR DENIAL

FIRST CAUSE FOR DENIAL OF APPLICATION

(Unprofessional Conduct)

131. The application of Talami International Health LLC, dba Palm Care Pharmacy is subject to denial under sections 4300, subdivision (c), section 4301, and section 4302, for unprofessional conduct as described in the paragraphs above of the First Amended Accusation, which are incorporated herein as though set forth in full.

SECOND CAUSE FOR DENIAL OF APPLICATION

(Grounds for Discipline or Discipline Based on Professional Misconduct)

132. The application of Talami International Health LLC, dba Palm Care Pharmacy is subject to denial under section 4302 for the existence of conditions that would constitute grounds for disciplinary action, or for an actual record of formal discipline based on professional misconduct, as described in the paragraphs above of the First Amended Accusation, which are incorporated herein as though set forth in full.

///

///

///

///

///

///

///

///

///

///

///

///

STATEMENT OF ISSUES AGAINST:

DREAM BORDER VILLAGE, LLC, DBA PALM CARE PHARMACY 1005

133. Respondent Dream Border Village, LLC, dba Palm Care Pharmacy 1005 submitted an application for a community pharmacy permit to the Board. In its application, Palm Care Pharmacy 1005 identified Amjad A. Alqazqi, who is the brother of Respondent Alkazaki, as being the sole owner and managing member of Respondent Dream Border Village, LLC. However, Palm Care Pharmacy 1005 is identified as one of the pharmacies owned by Respondent Alkazaki on Respondent Palm Care Pharmacy's website, Amjad A. Alqazqi is an employee of Respondent Palm Care Pharmacy, Palm Care Pharmacy 1005's address and telephone number are identical to the address and telephone number for Talami International Health, LLC's pharmacy, and a staff pharmacist of Respondent Palm Care Pharmacy was designated as the Pharmacist-in-Charge of Palm Care Pharmacy 1005.

134. Respondent Dream Border Village, LLC dba Palm Care Pharmacy 1005 did not disclose that Respondent Alkazaki, who was under multiple Board investigations with a pending accusation filed against his license and Respondent Palm Care Pharmacy's license, was actually the owner of and/or held management or control over Respondent Dream Border Village, dba Palm Care Pharmacy 1005; exhibited by actions including, arranging for Respondent Palm Care Pharmacy, 1005 to share a lease or premises with Talami, International Health LLC, Palm Care Pharmacy, owned by Respondent Alkazaki, and advertising that Palm Care Pharmacy 1005 as included within Respondent Alkazaki's chain of pharmacies.

CAUSES FOR DENIAL

FIRST CAUSE FOR DENIAL OF APPLICATION

(Unprofessional Conduct)

135. The application of Dream Border Village, LLC, dba Palm Care Pharmacy 1005 is subject to denial under sections 4300, subdivision (c), section 4301, and section 4302, for the facts alleged in paragraphs 128 and 129, and for unprofessional conduct as alleged in the above paragraphs of the First Amended Accusation, which are incorporated herein as though set forth in full.

SECOND CAUSE FOR DENIAL OF APPLICATION

(Grounds for Discipline or Discipline Based on Professional Misconduct)

136. The application of Dream Border Village, LLC, dba Palm Care Pharmacy 1005 is subject to denial under section 4302 for the existence of conditions that would constitute grounds for disciplinary action, or for an actual record of formal discipline based on professional misconduct, for the facts alleged in paragraphs 128 and 129, and for unprofessional conduct as alleged in the above paragraphs of the First Amended Accusation, which are incorporated herein as though set forth in full.

PRAYER

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

1. Revoking or suspending Original Pharmacy Permit Number PHY 53746, issued to Talami International, Inc., dba Palm Care Pharmacy; Usama Alkazaki, CEO/Secretary/CFO;

2. Revoking or suspending Pharmacist License Number RPH 69696, issued to Usama Alkazaki;

3. Revoking or suspending Pharmacist License Number RPH 76476, issued to Sarah Adel Abdulkareem Kala;

4. Prohibiting Talami International, Inc. from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any position with management or control of a license for five years if Pharmacy Permit Number 53746, issued to Talami International, Inc., dba Total Care Pharmacy, is placed on probation or until Pharmacy Permit Number 53746 is reinstated if it is revoked;

5. Prohibiting Usama Alkazaki from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any position with management or control of a license for five years if either Pharmacist License Number RPH 69696 or Pharmacy Permit Number 53746, issued to Talami International, Inc., dba Total Care Pharmacy, is placed on probation or until both Pharmacist License Number RPH 69696 and Pharmacy Permit Number 53746 are reinstated if either or both are revoked;

6. Prohibiting Sarah Adel Abdulkareem Kala from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any position with management or control of a license for five years if either Pharmacist License Number RPH 76476 or Pharmacy Permit Number 53746, issued to Talami International, Inc., dba Total Care Pharmacy, is placed on probation or until both Pharmacist License Number RPH 76476 and Pharmacy Permit Number 53746 are reinstated if either or both are revoked;

7. Ordering Talami International, Inc., dba Palm Care Pharmacy, Usama Alkazaki and Sarah Adel Abdulkareem Kala to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

8. Denying the application of Talami International Health LLC, dba Palm Care Pharmacy, Usama Alkazaki, Manager/CEO;

9. Denying the application of Dream Border Village LLC, dba Palm Care Pharmacy 1005; and,

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

DATED: 9/25/2023

Sodergren, Anne@DCA
Digitally signed by Sodergren, Anne@DCA
Date: 2023.09.25 12:51:04 -07'00'

ANNE SODERGREN
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
Complainant

SD2020801187
84157202.docx