NEVADA STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF CHARGES AND COMPLAINT AGAINST

MATTHEW OBIM OKEKE, M.D.

ADJUDICATION

Case No: 24-22461-2

Board Meeting Date: June 6, 2025

INDEX

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BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **MATTHEW OBIM OKEKE, M.D.,** **Respondent.**	**Case No. 24-22461-2**

FILED

JUN 27 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

FIRST-AMENDED COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Sarah A. Bradley, J.D., MBA, Deputy Executive Director and attorney for the IC, having a reasonable basis to believe that Matthew Obim Okeke, M.D., (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby files its First-Amended Complaint[2] in this matter, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active-probation license to practice medicine in the State of Nevada (License No. 14957). Respondent was originally licensed by the Board on October 8, 2003.[3]

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[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Bret W. Frey, M.D., Chowdhury H. Ahsan, M.D., PhD., FACC, and Col. Eric D. Wade, USAF (Ret.) (Public Member).

[2] When preparing the IC's pre-hearing statement and exhibits, the IC's counsel noticed that in the filed formal Complaint a statement made by Respondent in his response to the Board investigator that was received on March 11, 2020 regarding Patient C was attributed to Patient B in error. This First-Amended Complaint fixes that error and correctly quotes statements made by Respondent regarding Patients B and C. It also adds that Patient B received a prescription for Valium in addition to Suboxone from Respondent on November 8, 2019. It also corrects an incorrect statutory reference in Counts XXI–XXIV.

[3] Respondent's original license number issued on October 8, 2003, was 10668. Respondent was issued license number 14957 on September 6, 2013.

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Treatment of Patient A

2. Patient A[4] was a twenty-six (26) year-old female at the time of the events at issue.

3. Beginning on January 1, 2018, prescribing practitioners in Nevada were required to obtain a patient utilization report (Patient Report) regarding the patient from the Prescription Monitoring Program (PMP) before issuing an initial prescription for controlled substances listed in Schedules II, III, or IV, or an opioid that is a controlled substance listed in Schedule V, and at least once every ninety (90) days thereafter for the duration of the course of treatment of using the controlled substance..

4. The current medications list for Patient A on January 18, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 30 quantity with 1 per day for 15 days only, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, and Xanax .5 mg 60 quantity with 1 per day.

5. The current medications list for Patient A on February 23, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 30 quantity with 1 per day for 15 days only, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

6. The current medications list for Patient A on March 23, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 30 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

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[4] Patient A's true identity is not disclosed herein to protect her privacy but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

7. It should be noted that Patient A's current medication list was changed on March 23, 2018, from what was shown on February 23, 2018, because the limitation for Norco 5-325 mg for only fifteen (15) days, was removed.

8. The current medications list for Patient A on April 20, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

9. It should be noted that Patient A's current medication list was changed on April 20, 2018, from what was shown on March 23, 2018, because the quantity for Norco 5-325 mg was changed from thirty (30) to sixty (60).

10. The current medications list for Patient A on June 25, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

11. The current medications list for Patient A on July 20, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

12. The current medications list for Patient A on August 17, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with

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1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

13. The current medications list for Patient A on September 17, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

14. The current medications list for Patient A on October 15, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

15. The current medications list for Patient A on November 9, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

16. The current medications list for Patient A on December 10, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

17. It should be noted that Patient A's current medication list was changed on December 10, 2018, from what was shown on November 9, 2018, because the Xanax 1 mg 60 quantity with 1 per day was removed.

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18. The current medications list for Patient A on January 9, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

19. It should be noted that Patient A's current medication list was changed on January 9, 2019, from what was shown on December 10, 2018, because the Xanax 1 mg 60 quantity with 1 per day was added.

20. The current medications list for Patient A on February 5, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

21. The current medications list for Patient A on March 4, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

22. The current medications list for Patient A on April 4, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

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23. The current medications list for Patient A on May 2, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

24. The current medications list for Patient A on May 20, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

25. The current medications list for Patient A on June 26, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

26. The current medications list for Patient A on July 22, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

27. The standard of care for prescribing controlled substances is to avoid the use of benzodiazepines (such as clonazepam and alprazolam) with opioids (such as hydrocodone-acetaminophen, oxycodone-acetaminophen, and tramadol).

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28. There is an increased potential for respiratory depression with the use of opioids and benzodiazepines at the same time. Respondent asserts that he has not prescribed opioids to Patient A since September 25, 2013.[5]

29. However, Respondent did prescribe Patient A benzodiazepines from January 2018 to July 2019, and Respondent knew or should have known that Patient A was being prescribed opioids by another prescribing provider at that same time.

30. Patient A's Patient Report from the PMP confirms that she was receiving both benzodiazepines and opioids at the same time. Further, the medical records of Patient A reflect the use of both benzodiazepines and opioids at the same time in her "current medications" list as cited above in factual allegations ¶ 4 to 26.

31. It is concerning that multiple types and strengths of benzodiazepines (five (5) different types) and opioids (three (3) different types) are reflected in Patient A's medical records throughout her treatment with Respondent.

32. Patient A's Patient Report from the PMP does not support that she was actually taking five (5) different benzodiazepines and three (3) different opioids at the same time. Instead, it appears that the multiple types and strengths of benzodiazepines and opioids in Patient A's medical records is a failure by Respondent to ensure that Patient A's medical records correctly reflected what medications she was actually taking at the time of each visit.

33. Patient A's other medications contained in her medical records throughout this time period also appear to be inaccurate showing additional discrepancies such as three (3) different strengths of Adderall, each taken once per day, Bactrim DS 800-160 mg being taken by Patient A from January 18, 2018, through July 22, 2019,[6] two (2) different strengths of Ritalin each taken

[5] From the records received by the Board Investigator in this matter, it appears that Patient A first began to receive psychiatric care from Respondent on September 9, 2013. Only Respondent's care of Patient A from January 2018 to July 2019 will be addressed in this Complaint.

[6] Bactrim DS 800-160 mg is an antibiotic used to treat infections. Upon information and belief, it is unlikely that Patient A would take an antibiotic for more than a year without a history of infections or other medical issues being noted. Patient A's medical records maintained by Respondent reflect no history of urinary tract infections or other conditions that may warrant the use of an antibiotic. There is a note about Patient A having a urinary tract infection in January 2019 in the records maintained by another health care provider providing care to Patient A during this same time period. However, Respondent's records reflect no such note, just continuing use of antibiotics by Patient A at every visit with Respondent during this time period. Upon information and belief, the reference to Patient A's use of Bactrim DS 800-160 mg form January 18, 2018, to July 22, 2019, is an example of Respondent's failure to maintain clear, legible, accurate, and complete medical records for Patient A.

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once per day, and two (2) different strengths of Zoloft each taken once per day.

34. The discrepancies noted in factual allegation at ¶ 30 to 33 constitute a failure by Respondent to ensure that Patient A's medical records correctly reflected what medications she was actually taking at the time of each visit.

35. Upon information and belief, Respondent copied and pasted progress notes from visit to visit for Patient A, which led to a failure to maintain clear, legible, accurate, and complete medical records for Patient A.

36. Upon information and belief, Respondent's care of Patient A showed a lack of diligence in both documentation, review, and management of her medications which fell below the standard of care.

37. In his response to the Board Investigator regarding Patient A, Respondent stated, "I check the PMP regularly."

38. If the statement in ¶ 37 was true, Respondent should have been aware of Patient A's concurrent use of benzodiazepines and opioids.

39. However, the PMP records show that Respondent did not conduct a query of Patient A's prescription history in the PMP to obtain her Patient Report at any time from January 2018 to July 2019.

40. The quantities of controlled substances prescribed to Patient A by Respondent did not always match the progress notes in Patient A's medical records.

41. At times, Respondent provided Patient A with prescriptions that were more than a thirty (30) day supply, even though he was seeing her monthly to manage her medications.

42. Respondent was out of the United States from November 8, 2019, to December 8, 2019.

Treatment of Patient B

43. Patient B[7] was a forty-seven (47) year-old male at the time of the events at issue.

44. Respondent wrote a prescription for a Schedule III controlled substance, Suboxone, and a Schedule IV controlled substances, Valium, for Patient B on November 8, 2019.

[7] Patient B's true identity is not disclosed herein to protect his privacy but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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45. There is no progress note correlating to a visit on November 8, 2019, when Patient B received the prescription from Respondent.

46. Upon information and belief, Respondent did not examine Patient B on November 8, 2019, prior to giving him the prescription for the Schedule III and Schedule IV controlled substances, which is a violation of the standard of care.

47. The prescriptions for Patient B were written on one (1) paper prescription dated November 8, 2019, that contained a signature from Respondent.[8]

48. Respondent was out of the country on November 8, 2019.

49. Respondent stated in his response to the Board investigator that "I saw this patient 10/10/2019 and he saw another provider in my office 11/15/2019. I gave him a script for the date I saw him and I did not post date any script for him."

50. Upon information and belief, Respondent allowed another person in his office to either sign his name to the prescription for Patient B or Respondent pre-signed and/or post-dated the prescription for Patient B prior to leaving the country.

51. PMP records show that Respondent did not check Patient B's Patient Report from the PMP until February 2020.

52. PMP records do not show that Respondent conducted queries of Patient B in the PMP prior to prescribing controlled substances to him, or every ninety (90) days after prescribing controlled substances to him as required by Nevada law.

53. A review of Patient B's Patient Report from the PMP shows that Patient B was given a refill for Valium too early.

54. Respondent gave Patient B a thirty (30) day supply of Valium (quantity 60, 5 mg) on April 11, 2019, April 24, 2019, and May 9, 2019.

55. According to Patient B's Patient Report from the PMP, all three (3) of these prescriptions, in addition to others, were written by Respondent.

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[8] Please note that the prescription provided to Patient B contains a signature that looks very much like Respondent's signature as seen in other medical records in this matter and other Board matters. This is unlike the prescriptions provided to Patients C, D, and E that contain Respondent's handwritten name, but do not look like his signature.

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Treatment of Patient C

56. Patient C[9] was a fifty-three (53) year-old male at the time of the events at issue.

57. Respondent wrote a prescription for Patient C for controlled substances on November 27, 2019.

58. There is no progress note correlating to a visit on November 27, 2019, when Patient C received the prescription from Respondent.

59. Upon information and belief, Respondent did not examine Patient C on November 27, 2019, prior to giving him the prescription which is a violation of the standard of care.

60. The prescription for Patient C was a paper prescription dated November 27, 2019, that contained a signature from Respondent and/or Respondent's handwritten name. [10]

61. Respondent was out of the country on November 27, 2019.

62. Respondent stated in his response to the Board investigator regarding Patient C that "I have never seen this patient in any setting that I can remember. I did not give him any prescription. I do not have a record of seeing him or treating him."

63. Upon information and belief, Respondent allowed another person in his office to either sign his name to the prescription for Patient C or Respondent pre-signed the prescription for Patient C prior to leaving the country.

64. PMP records show that Respondent did not check Patient C's Patient Report from the PMP until February 2020.

65. If Respondent's statement to the Board investigator as contained in ¶ 62 was true and Patient C was never his patient, it would be a violation of law for Respondent to check Patient C's Patient Report in the PMP in February 2020.

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[9] Patient C's true identity is not disclosed herein to protect his privacy but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

[10] The signature for Respondent on this prescription looks different than other signatures for Respondent shown in other documents. It is possible that Respondent's name was simply written on the prescription by another staff member. For example, the signature from Respondent on the paper prescription for Patient B looks different than that on the prescription for Patient C.

66. PMP records do not show that Respondent conducted queries of Patient C in the PMP prior to prescribing controlled substances to him or every ninety (90) days after prescribing controlled substances to him as required by Nevada law.

Treatment of Patient D

67. Patient D[11] was a seventy-four (74) year-old female at the time of the events at issue.

68. Respondent wrote a prescription for Patient D for controlled substances on November 27, 2019.

69. Respondent is referenced in some documents from Sana Behavioral Health (Sana) as the attending physician for Patient D during her stay at Sana.

70. Respondent's name is signed on the Interdisciplinary Team Meeting note dated November 26, 2019.

71. However, Respondent was out of the country on both November 26, 2019, and November 27, 2019.

72. Sana records support that Patient D was actually seen by ML, M.D., and DP, APRN while at Sana.

73. Upon information and belief, Respondent did not examine Patient D on November 27, 2019, prior to giving her the prescription which is a violation of the standard of care.

74. The prescription for Patient D was a paper prescription dated November 27, 2019, that contained a signature from Respondent and/or Respondent's handwritten name.[12]

75. Delegating signatory approval for Patient D for the prescription and/or Patient D's medical records at Sana is a violation of the standard of care.

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[11] Patient D's true identity is not disclosed herein to protect her privacy but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

[12] The signature for Respondent on this prescription looks different than other signatures for Respondent shown in other documents. It is possible that Respondent's name was simply written on the prescription by another staff member. For example, the signature from Respondent on the paper prescription for Patient B looks different than that on the prescription for Patient D.

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76. Upon information and belief, Respondent allowed another person in his office to either sign his name to the prescription for Patient D or Respondent pre-signed the prescription for Patient D prior to leaving the country.

77. PMP records do not show that Respondent conducted queries of Patient D in the PMP prior to prescribing controlled substances to her or every ninety (90) days after prescribing controlled substances to her as required by Nevada law.

Treatment of Patient E

78. Patient E[13] was a fifty-five (55) year-old female at the time of the events at issue.

79. Respondent wrote a prescription for Patient E for Klonopin on November 15, 2019.

80. Respondent is referenced in some documents from Sana as the attending physician for Patient E during her stay at Sana.

81. Upon a review of the Patient Report from the PMP for Patient E, Patient E also received and filled another prescription for Klonopin from DP, APRN on November 15, 2019.

82. Both prescriptions for Patient E are for a quantity of 60, 1 mg tablets for 30 days.

83. Respondent was out of the country on November 15, 2019.

84. Sana records support that Patient E was actually seen by ML, M.D., and DP, APRN while at Sana.

85. Upon information and belief, Respondent did not examine Patient E on November 15, 2019, prior to giving her the prescription which is a violation of the standard of care.

86. The prescription for Patient E was a paper prescription dated November 15, 2019, that contained a signature from Respondent and/or Respondent's handwritten name.[14]

87. Delegating signatory approval for Patient E for the prescription is a violation of the standard of care.

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[13] Patient E's true identity is not disclosed herein to protect her privacy but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

[14] The signature for Respondent on this prescription looks different than other signatures for Respondent shown in other documents. It is possible that Respondent's name was simply written on the prescription by another staff member. For example, the signature from Respondent on the paper prescription for Patient B looks different than that on the prescription for Patient E.

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88. Upon information and belief, Respondent allowed another person in his office to either sign his name to the prescription for Patient E or Respondent pre-signed the prescription for Patient E prior to leaving the country.

89. PMP records do not show that Respondent conducted queries of Patient E in the PMP prior to prescribing controlled substances to her, or every ninety (90) days after prescribing controlled substances to her as required by Nevada law.

90. In response to the Board investigator regarding Patients D and E, Respondent concedes that he traveled on the days that prescriptions were provided to those patients and stated, "I would guess that they used my name to fill a prescription" and that he "did not authorize the prescription in any way."

91. Upon information and belief, Respondent has not reported the use of his prescribing credentials by others to law enforcement and/or the Nevada Board of Pharmacy.

92. Upon information and belief, if Respondent's statement to the Board investigator in ¶ 90 was correct, Respondent would have and/or should have reported that unauthorized prescribing to law enforcement and/or the Nevada Board of Pharmacy.

93. Upon information and belief, Respondent did not complete the required queries of his prescribing history during 2019 (at least one query of his prescribing history every six months) in order to detect unauthorized use of his prescribing credentials by others.

94. Upon information and belief, if Respondent had completed the required queries of his prescribing history in the PMP in 2019, he would have identified any unauthorized use of his prescribing credentials.

COUNTS I–V

NRS 630.301(4) - Malpractice

95. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

96. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

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97. NAC 630.040 defines malpractice as "the failure of a physician . . . in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."

98. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A when he prescribed benzodiazepines to her while she was taking opioids at the same time. Further, when he prescribed controlled substances to Patients A through E via paper prescriptions when he 1) was out of the country, 2) failed to check each patient's PMP prior to prescribing them controlled substances as required by law, and 3) failed to examine the patients prior to writing them prescriptions for controlled substances.

99. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNTS VI–X

NRS 630.3062(1)(a) - Failure to Maintain Complete Medical Records

100. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

101. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient" constitute grounds for initiating discipline against a licensee.

102. Respondent failed to maintain complete medical records relating to his care of Patient A by failing to ensure that her medical records were clear, legible, accurate, and complete with regard to the medications that she was taking at each visit.

103. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patients A through E, by failing to completely and correctly document his medical care and treatment for Patients A through E and/or by over-reliance on templated material in the medical records for Patients A through E and/or by over-reliance on copy and paste for his patients' medical records from visit to visit, causing the medical records for Patients A through E to not be timely, legible, accurate, and complete.

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104. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNTS XI–XVI

NRS 630.306(1)(b)(3) - Violation of Statutes and Regulations of the Nevada State Board of Pharmacy

105. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

106. NRS 639.23507 requires that a prescribing practitioner before issuing an initial prescription for controlled substances listed in schedule II, III, or IV, or an opioid that is a controlled substance listed in schedule V, and at least once every ninety (90) days thereafter for the duration of the course of treatment using the controlled substance, obtain a patient utilization report (Patient Report) regarding the patient from the PMP.

107. Respondent failed to obtain Patient Reports for Patients A through E as required by NRS 639.23507.

108. Respondent also failed to self-query his prescribing history in the PMP as required by Nevada law.

109. This conduct violates NRS 630.306(1)(b)(3).

110. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNTS XVII–XX

NRS 630.3062(1)(h) - Fraudulent, Illegal, Unauthorized, or Otherwise Inappropriate Prescribing of Controlled Substances Listed in Schedule II, III, or IV

111. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

112. By pre-signing paper prescription pads and providing them to office staff and/or other practitioners so that Respondent's name, Nevada State Board of Pharmacy registration number, and Board license number could be used to prescribe medications to Patients B through E while Respondent was out of the country, Respondent engaged in fraudulent, illegal,

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unauthorized, or otherwise inappropriate prescribing of controlled substances listed in schedule II, III, or IV.

113. This conduct violates NRS 630.3062(1)(h).

114. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNTS XXI–XXIV

NRS 630.306(1)(b)(1) - Engaging in Conduct Which is Intended to Deceive

115. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

116. By stating in writing, "I check the PMP regularly" in a written response to the Board's investigator regarding Patient A, when records from the PMP show that Respondent never queried Patient A's Patient Report in the PMP, Respondent engaged in deceptive conduct to the Board and/or IC.

117. By stating in writing that he did not prescribe medications and/or authorize other people to prescribe medications to Patients C, D, and E under his name and, "I would guess that they used my name to fill a prescription" and that he, "did not authorize the prescription in any way," which is not supported by the records in this case, Respondent engaged in deceptive conduct to the Board and/or IC.

118. This conduct violates NRS 630.3062(1)(b)(1).

119. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

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3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

5. That the Board make, issue, and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

6. That the Board take such other and further action as may be just and proper on these premises.

DATED this 27th day of June, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 27th day of June, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
BRET W. FREY, M.D.
Chairman of the Investigative Committee

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2

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against MATTHEW OBIM OKEKE, M.D., Respondent.	Case No.s: 24-22461-1 24-22461-2 24-22461-3 24-22461-4 24-22461-5

FINDINGS AND RECOMMENDATIONS

FILED

MAY 19 2025

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

TO: Sarah A. Bradley
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste. 280
Henderson, NV 89121

The above-referenced matters came for hearing on October 21, 2024 through October 24, 2024. The hearings were held by video conferencing between the State of Nevada Board of Medical Examiners' Reno and Las Vegas offices, with counsel for the Investigative Committee of the State of Nevada Board of Medical Examiners (the "IC"), Sarah A. Bradley, and the undersigned hearing officer appearing in Reno, and Respondent Dr. Matthew Obim Okeke ("Respondent") appearing from Las Vegas along with his counsel Liborius Agwara, Esq. The matters were presented out of sequence commencing with Matter 4. For purposes of ease for drafting this Findings and Recommendations, the matters will be addressed in the same order.

Matter 4

Matter 4 is premised upon a Complaint for seven claims for relief. Count I is Malpractice, a violation of NRS 630.301(4), premised upon the allegation, in summary, that is was improper for Respondent to prescribe a benzodiazepine (specifically alprazolam, the brand name of which

is Xanax) when he knew or should have known that the patient was also taking opioids; and/or that Respondent failed to consider outside medical records regarding the patient's use of opioids; and/or by failing to properly document the patient's treatment.

Count II alleges a violation of NRS 630.3062(1)(a), Failure to Maintain Complete Medical Records, and is premised upon the allegations that the patent records at issue were copied and pasted with data from other patients; and/or backdated; and/or failed to document review or discussion of the patient's Prescription Monitoring Program ("PMP") report; and/or failed to ensure the patient medications were updated and accurate each visit; and/or failed to document any attempt to obtain outside medical records related to the patient's use of opioids as prescribed be any other provider.

Count III is a charge of Engaging in Conduct that is Intended to Deceive, a violation of NRS 630.306(2)(b)(1), and is premised upon the allegation that Respondent was not forthright when representing to the Investigative Committee of the Nevada Board of Medical Examiners (the "IC") that he had only seen the subject patient twice.

Count IV alleges a violation of NRS 630.254(3), Failure to Notify the Board Regarding Office Closure and Location of Patient Records as related to Respondent's closing of his office referred to as "Grand Desert."

Count V, Failure to Notify the Board Regarding Change of Mailing Address, a violation of NRS 630.254(1), is self-explanatory and relates to the closing of Respondent's office.

Count VI is for Failure to Provide Patient Records to Patient Upon Request, a violation of NAC 630.230(2), and is premised upon the allegation that requested patient records had not been timely provided and that the location of the records remains unknown.

The final charge, Count VII, is for Knowing or Willful Failure to Comply with a Provision of NRS Chapter 630, a violation of NRS 630.3065(2)(c), and is premised upon Respondent's alleged knowingly and willful failure to have provided contact information upon the closure of his office and his failure to disclose the location of the patient records that are the subject of Count VI.

Throughout the course of the hearing, IC Exhibits 1 through 10 were admitted.

The IC's first witness was the IC's Chief Investigator Ernesto Diaz, who authenticated exhibits and through whom Exhibits 1-5 were admitted. Mr. Diaz also supported Count III, Engaging in Conduct that is Intended to Deceive, a violation of NRS 630.306(2)(b)(1), by testifying that medical records contradict Respondent's response to IC inquiries regarding having only seen Patient A twice.

The IC's next witness was Bryan Czerniski, M.D., a licensed Nevada psychiatrist, who testified to his credentials (*see* Exhibits 9-10, which were admitted), and opined that Respondent fell below the standard of care by prescribing a benzodiazepine, specifically alprazolam, to a patient who was on opioids and by further failing to document related risk factors. Transcript pp. 47-50 (abbreviated hereafter as "T" with page numbers following). According to Dr. Czerniski, Respondent should have checked the patient's PMP report before prescribing any controlled substance. T 50. Dr. Czerniski further testified that the combination of a benzodiazepine with an opioid can lead to respiratory distress and increase the chances of "mortality by tenfold," (T 53-54), and that alprazolam (a benzodiazepine) should not be utilized long-term for someone with anxiety due to the state of withdrawal causing more anxiety, especially if there is a history of alcohol use disorder because the withdrawal can induce alcohol cravings. T 56-57, 63-65, 86. Dr. Czerniski expressed concern about the alprazolam prescription due to a history of seizures and the withdrawal increasing the chance of seizures. T 57-58. Based upon these risks, Dr. Czerniski testified that the alprazolam should have been tapered off. T 59.

According to Dr. Czerniski, Respondent's records indicate that after Respondent checked the PMP report, he did decrease the alprazolam dosage but did so too abruptly without proper titration and then inexplicably bumped the dosage back up. T 60-61, 107. Dr. Czerniski further testified that there is no indication that Respondent collaborated to establish a shared treatment program with the patient's other provider(s) in light of the alprazolam he had prescribed and opioid prescription another provider had prescribed, nor did Respondent document the basis for his alprazolam prescription and dosage changes. T 62, 99.

As to Respondent's medical records, Dr. Czerniski noted concerns about notations being cloned, meaning copied and pasted from other records. T 66, 71-3. He also expressed that the medication list was unclear due to duplication and dosages, and that date entries were either auto-populated after the visit or subject to having been changed, which is contrary to records being required to be maintained as they were made after they are finalized. T 67-68, 71.

Adverse reactions as a result of the benzodiazepine prescription of alprazolam with the opioids as specific to Patient A was brought out in cross-examination, as to which Dr. Czerniski testified that the adverse reactions resulted in twelve emergency department visits, with ten of those during times the PMP report was kept, and eight of those having followed within two days of the Xanax prescription (alprazolam, which again, is a benzodiazepine). T 78-79. Notes related thereto provide "[p]rofound sedation due to medication of substances" but there is no way of knowing if the patient was compliant with medication instructions; although, the description is consistent with an overdose of alprazolam or a mixture of alprazolam and opiates, which Dr. Czerniski opined was the cause. T 79-83.

It was established on cross-examination that the patient had already been prescribed benzodiazepines by another provider, Dr. Kroegel, in 2019, and that when Respondent saw the patient three years later in September 2021 and October 2021, according to Dr. Czerniski, Respondent should have taken the patient off the alprazolam in consultation with the patient's other providers by tapering the patient off in consideration of the patient's seizure disorder and "rebound anxiety." T 89-96, 99-100.

The IC's next witness was Darla Zarley who is the Prescription Monitoring Program Administrator for the Nevada State Board of Pharmacy. T 120. Relevant to the charges, Ms. Zarley testified that the PMP records indicate that Respondent first ran a PMP inquiry for the patient on September 16, 2021, at which time Respondent prescribed the patient alprazolam (a benzodiazepine) despite the patient already being prescribed oxycodone (an opioid). T 123.

The next to testify was Johnna LaRue, the Deputy Chief of Investigations and Compliance Officer for the Nevada State Board of Medical Examiners. T 131. Ms. LaRue testified that Respondent's license was moved from active to inactive on June 9, 2023 in accordance with

admitted Exhibit 6, which is an email from Respondent's counsel requesting that Respondent's license be moved to inactive. Exhibit 7, which is an allegation letter regarding Respondent's failure to provide Patient B his or her records, was also admitted through Ms. LaRue. T 136-38. Exhibit 8, which is an envelope marked undeliverable to Respondent's address on file with the Board was also admitted. T 138-39. Ms. LaRue further testified that Patient B's records were never provided despite having been requested. T 140. On cross-examination, Ms. LaRue indicated that she did not follow up on the returned mail with Respondent by calling him but that she had tried to email him with no response. T 142-43.

Respondent for his case presented only his testimony, by which he testified that it is not his practice to prescribe benzodiazepines but will continue such prescriptions for existing users (T 146); Respondent lowered the patient's benzodiazepine prescription because he was not comfortable with the amount currently prescribed (T 148-49); the patient was not prescribed the benzodiazepine by him originally (T 149); that the reduction he gave was drastic so he increased it again to help the patient cope (T 150); and that he still maintains the address where his practice was located and that the Board has on file but there was no one there to sign for the mail the Board sent that was returned (T 150).

On cross-examination, Respondent acknowledged that he did not note any reasoning for the changes to the benzodiazepine prescription dosages. T 151. Then on re-direct, Respondent testified that the two times he saw the patient in 2021 and 2022 he was just covering and, therefore, did not want to make drastic changes to the patient's prescriptions. T 153.

Counts I and II

As to whether Respondent committed malpractice by prescribing benzodiazepines while he knew or should have known that the patient was taking opioids, the rub is that the patient was already prescribed benzodiazepines when the patient was seen by Respondent, who testified he was covering for another provider. Per the IC's expert, although it was inappropriate to allow the benzodiazepine prescription to continue, that being Xanax in particular, it also was not appropriate to cease the prescription altogether. Given the foregoing, I cannot recommend a finding that Respondent committed malpractice by continuing to prescribe the benzodiazepine.

However, it remains that Respondent's records are not appropriately reflective of the basis for his actions with respect to the continuing prescription, its increase and decrease, and there is no indication that he took care to address the problems that arise with the prescription in consideration of concurrent opioid use. The records also have cloned entries. The manner by which the records tracked prescriptions is also problematic in that, as testified to by Dr. Czerniski, the medication list was unclear due to duplication and dosages, and that date entries were either auto-populated after the visit or subject to having been changed, which is contrary to records being required to be maintained as they were made after they are finalized. T 6-68, 71. The failure to make and maintain appropriate medical records is pleaded as the basis for malpractice claim as well as the failure to maintain complete medical records claim. Given the duplicity, I recommend finding a violation on Count II.

Count III

Count III is engaging in conduct that is meant to deceive and is premised upon Respondent's written response to the IC's investigation whereby Respondent indicates that he only saw the patient at issue twice, which was not accurate. Respondent actually saw the patient eight times - twice in 2021 and six times in 2018. T 102; Exhibit 3.

The letter upon which Count II is based was written by Respondent's counsel but was adopted by Respondent and his signature appears on it. *See* Exhibit 2. The letter from the IC that the Respondent was answering referenced treatment of the patient "for years" and was focused on the prescription of narcotics to the identified patient. *See* Exhibit 1. The times that Respondent saw the patient and prescribed narcotics were the two visits in 2021.

In reviewing the statute, NRS 630.306, it is focused on actions that are the basis for initiating an investigation and, if warranted, disciplinary proceedings, and is not tailored to responding to the IC once an investigation is underway; but, even assuming the statute could be applied in such an instance, given the context of the inquiry and the timeframe Respondent could assume was at issue, I cannot find that Respondent referencing the two recent visits rises to the level of an intentional deception, particularly when Respondent provided all the records that included the visits from 2018. T 37-38.

Counts IV, V, and VI

Counts IV, V, and VI are for failure to notify the Board about the office closure and location of records; failure to notify the Board regarding a change of address; and failure to provide patient records to a patient upon request. Respondent did not defend his failure to provide patient records. As to the office closure and change of address, Respondent testified that he maintains that address although he closed his practice.

Given Respondent closed his practice, mail sent by the Board was returned, and the patient records remain unaccounted for, I submit that Respondent should be held accountable for each of these three counts. If a practitioner closes an office and cannot be reached by the Board by certified mailing, that is a problem and is the exact problem the mandates outlined in the counts are meant to address. It is particularly unacceptable that the patient records at issue in Count VI remain unaccounted for.

Matter 1

Matter 1 commenced upon the amendment of the Complaint as provided for on the record. A true and correct copy of the Complaint as amended was filed on October 29, 2024. The exhibits were also addressed and updated on the record. The parties stipulated that Respondent was out of the country from February 26, 2017 through March 11, 2017; September 27, 2017 through October 2, 2017; and June 30, 2018 through July 7, 2018; and November 9, 2018 through November 23, 2018, as stated in paragraph two of the Complaint as amended.

Counts 1-66 are for malpractice, a violation of NRS 630.301(4), as alleged with regard to patients A through NNN, and is premised upon the allegation that Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when rendering medical services because he billed for services not rendered, prescribed controlled substances via paper prescriptions when he was out of the country, failed to check the PMP as required by Nevada law, and failed to examine patients prior to writing prescriptions for controlled substances.

Counts 67 through 79 relate to patients A through M and are for failure to maintain complete medical records, a violation of NRS 630.3062(1)(a), premised upon Respondent's

alleged failure to completely and correctly document medical care and treatment and/or by over-reliance on templated material in the records, causing the same to be untimely, illegible, inaccurate, and incomplete.

Counts 80 through 136 relate to patients C, E, and J through NNN excluding L and M, and are premised upon alleged violations of statutes and regulations of the Nevada State Board of Pharmacy, a violation of NRS 630.306(1)(b)(3), specifically Respondent's alleged failure to run PMP reports as required to prescribe controlled substances.

Counts 137 through counts 197 plead violations of NRS 630.3062(1)(b)(3), Fraudulent, Illegal, Unauthorized, or Otherwise Inappropriate Prescribing of Controlled Substances Listed in Schedule II, III, or IV, in relation to patients C, E, G, and I through NNN, alleging that Respondent pre-signed prescription pads for his staff or other practitioners to utilize while he was out of the country.

Counts 198 to 204 are premised upon alleged violations of Engaging in Conduct that is Intended to Deceive, a violation of NRS 630.306(2)(b)(1), in relation to patients A, B, D, E, F, G, and H based upon providing services under his name and NPI number that he did not provide, which is deceptive.

Counts 205 through 211, relate to alleged violations of NRS 630.305(1)(d), Charging for Services Not Rendered, for allegedly charging patients A, B, D, E, F, G, and H for services that were not rendered.

The parties stipulated to numerous exhibits as identified on the record and removed others based upon Respondent's stipulation to not running PMP's for 57 patients as is relevant to Counts 80-136.

The IC's first witness was Ernesto Diaz, the Board's Chief Investigator, who testified as to Respondent's National Provider Identification number and to patient visit records of November 12-14, 2018 and November 20-21, 2018 – dates Respondent was out of the country. Transcript of October 22, 2024, pp. 50-56. The same testimony was given for the dates of February 28, 2017; September 27, 2017; November 24, 2018; November 9-10, 2018; November 16-19, 2018, in

addition to some overlap of prior dates. T 57-59. On cross-examination, Respondent implied the visits were by "telemed." T 60-62.

The IC then called Dr. Jayleen Chen, a psychiatrist, who testified as to her qualifications and that Respondent did not meet the standard of care by failing to have established a "bona fide patient/prescriber relationship" when having purportedly seen patients and prescribing controlled substances while out of the country, as well as failing to write progress notes to support the prescriptions. T 62, 67-71.

Per Dr. Chen, billing records indicate that the visits were office visits, that being that the place of service was the office; and, if the visits were by telehealth, that should have been noted. T 75-79. Dr. Chen also testified that electronic prescriptions, versus paper, are now the norm for prescribing controlled substances but, in relation to this matter, Respondent purported to have issued paper prescriptions while out of the country. T 80. It was surmised by Dr. Chen that the paper prescriptions were dated in such a manner as to be issued while Respondent was out of the country (T 81-86) as opposed to being filled out with "do not fill" until a certain date, which is the proper manner to issue future prescriptions. T 83. Dr. Chen also testified that it is not allowed for someone other than Respondent to have given the paper prescriptions to the patients. T 87. Dr. Chen further testified that Respondent's records contained copying and pasting and duplicate medication listings with differing dosages. T 89-91, 107. Dr. Chen also confirmed that a check of the PMP database was not undertaken when it should have been. T 93. On cross-examination, Dr. Chen was questioned about other care workers who are part of a treatment team billing under Respondent's Medicare billing code, which was referenced as "14." T 102-103. On redirect Dr. Chen testified that compromised prescribing credentials must be reported. T 110.

Respondent testified and addressed his experience (T 118-19); that he did not run the required PMP inquiries based upon his electronic medical record program giving the same information (T 119-21, 123-26, 138); and that, at the time at issue, it was acceptable to "postdate" written prescriptions (that being to write a future date), which is what Respondent did so that his patients would not run out of their prescriptions and face withdrawal symptoms (T 121, 126, 140-42). Respondent also testified that he was on the telephone with the provider seeing his patients

on unidentified occasions when the provider treating the patient had questions (T 122-23), and that other levels of providers would bill Medicaid under a general billing number that was also reflective of the number he used and, therefore, the usage of that number was not necessarily identifying as to him (T 126-131). On cross-examination, Respondent testified that a billing code "20" as opposed to a "14" would be the other psychiatrist affiliated with the office or the nurse practitioner but likely the nurse practitioner because the other psychiatrist would have put their name (T 136-37).

After Respondent's testimony, Darla Zarley of the Nevada State Board of Pharmacy was recalled as a witness by the IC, and testified that Respondent's EMR system was not integrated with the PMP system until July of 2020 (T of October 23, 2024, pp. 6-7) and reiterated that a PMP report was required to be run as of January 1, 2018. T 9.

Counts I – LXVI

Counts I-LXVI are for malpractice, defined by NAC 630.040 as "the failure of a physician . . . in treating a patient to use reasonable care, skill, or knowledge ordinarily used for similar circumstances," and are premised upon billing for services not rendered, prescribing controlled substances via paper prescriptions while out of the country, failing to run PMP reports as required by law, and failing to examine patients prior to writing prescriptions for controlled substances.

Respondent stipulated to being out of the country for the dates at issue and, therefore, did not examine the patients (and only conferring by phone with providers who did see them on occasion per his own testimony); admitted to not running the PMP reports as required by law; postdated prescriptions without complying with NAC 453.450(4), which applies to Schedule II substances, and otherwise postdated written prescriptions for controlled substances outside of Schedule II substances; and billed for treatment of the identified patients as demonstrated by billing records that, regardless of the PT code (which Respondent referred to as a Medicaid code that could apply to other levels of providers), reference Respondent as the provider by and

through his name, electronic signature, and NPI Code. As such, I recommend finding against Respondent for these counts.[1]

Counts LXVII - LXXIX

These counts allege that Respondent failed to maintain timely, eligible, accurate and complete medical records relating to the diagnosis, treatment and care of the identified patients by failing to completely and correctly document his care and treatment for each of the patients at issue and/or over-relying on templated material. The only direct testimony regarding the same came from Dr. Chen who substantiated the allegations and, therefore, I suggest finding against Respondent on these counts.

Counts LXXX – CXXXVI

These counts are for violation of statutes and regulations of the Nevada State Board of Pharmacy and is premised upon failure to run the PMP reports as addressed in counts I – LXVI. Based upon Respondent's admission to failing to run the PMP reports, Respondent should be found to have violated these counts.

Counts CXXXVII – CXCVII

These counts are for fraudulent, illegal, unauthorized, or otherwise inappropriate prescribing of controlled substances listed in Schedule II, III, or IV and are based upon the postdating of the prescriptions as was addressed in counts I – LXVI; however, the premise is that Respondent postdated the prescriptions and then provided them to office staff or other practitioners to hand out while he was out of the office. There is no testimony that was proffered to substantiate that and, contrary thereto, Respondent indicates that he postdated the prescriptions and himself provided them during previous appointments. October 22, 2024 T 139-40. This was not refuted by the IC and, therefore, I cannot recommend that Respondent be held in violation of these counts as pleaded.

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[1] There are numerous patients at issue and, given the parties treated them as a block to which all allegations and defenses apply, the undersigned hearing officer likewise did so and, therefore, did not address each patient individually in making the above findings. This applies to all of the counts addressed with respect to Matter 1.

Counts CXCVIII – CCIV and Counts CCV - CCXI

These counts are in relation to seven identified patients who Respondent purported to provide services to while he was out of the country and are premised upon engaging in conduct intended to deceive and charging for services not rendered.[2] As set forth herein, I find that services were purportedly rendered and billed for that did not take place. To the extent that is deceptive, I recommend a finding that Respondent violated these counts.

Matter 2

This matter is similar to Matter 1 in that it alleges malpractice based upon prescribing an identified patent benzodiazepines when the patient was taking opioids and also prescribing five patients controlled substances by paper prescription when he was out of the country; failing to run each patient's PMP report; and failing to examine the patients prior to writing the prescriptions. The complaint also alleges counts for failure to maintain complete medical records in the same manner as addressed in Matter 1, that being over reliance upon templated material and/or cutting and pasting; counts premised upon violation of statutes and regulations of the Nevada State Board of Pharmacy for the failure to run the PMP reports; counts for fraudulent, illegal, unauthorized, or otherwise inappropriate prescribing of controlled substances listed in Schedule II, III, or IV by pre-signing paper prescriptions and providing them to staff and/or other practitioners to provide to patients while he was out of the country; and counsel for engaging in conduct that is intended to deceive by making misleading statements in response to the IC investigation. Matter 2 was heard on October 23, 2024 and continued through October 24, 2024 and is summarized as follows.

The IC's first witness was its Chief Investigator Ernesto Diaz who authenticated records and addressed Respondent's response to the IC investigation letter whereby Respondent indicated that he never authorized Dr. Victor Bruce to write any prescriptions. October 23, 2024 Transcript, pp. 20-41. Mr. Diaz also testified that as of his time at the IC, since March 2020, he had not received any information about Respondent's prescribing credentials being compromised. T 43.

[2] The IC's statutory citation at to counts CXCVIII - CCIV is "NRS 630.306(2)(b)(1)" but is apparently meant to be NRS 630.306(1)(b)(1).

On cross-examination Mr. Diaz was asked about the scope of any investigation he personally performed. T 46-49.

The IC next called Darla Zarley, the Prescription Monitoring Program Administrator with the Nevada State Board of Pharmacy who testified that the PMP reports run for the patients at issue were not run within the time period at issue as required by law. T 51-54. Ms. Zarley also testified that she was not notified of Respondent's prescribing credentials having become compromised. T 55. On cross-examination, Ms. Zarley testified that the PMP report showed that Respondent prescribed controlled substances to the patients subject to the complaint (T 57), and that the prescription should have been called in by the prescriber who saw the patient (T 59). As to Exhibit 20 in particular, Ms. Zarley testified that it looked like a person named "Mary" called the prescription in on behalf of Respondent. T 59-60. In response to questioning from the undersigned hearing officer, Ms. Zarley further testified that the prescribing credentials would come from whoever called in the prescription and, as to Exhibit 20, the number given was not Respondent's but could have been written down wrong. T 61-64. Respondent's prescribing credentials were then identified for the record. T 64-65. It was then established that a prescriber would not necessarily know if his or her credentials were being improperly used, which is why prescribers are required to run their related reports every six months to ensure their credentials are related solely to prescriptions they have issued. T 65-66. In follow up it was established that Exhibit 17 contains Respondent's credentials, as is the case for Exhibit 25, and a query for Respondent attributes Exhibit 20 to him. T 67-70. As for each of the prescriptions in Exhibits 17, 20, and 25, they were called in and would have been written down by the pharmacist. T 71.

The IC's next witness was Jayleen Chen, M.D., a psychiatrist who testified to her credentials and experience. Dr. Chen then testified that she opined that Respondent fell below the standard of care by prescribing benzodiazepines to Patient A who has been receiving opioids from another provider as well as having failed to run the PMP and took issue with the clarity and accuracy, by way of copying and pasting, of Patient A's records. T 79-91, 97-98, 101, 109-10, 126-27. Dr. Chen then addressed Respondent prescribing a controlled substance to Patient B on a date Respondent should have seen the patient to properly do so but was out of the country and for

which no PMP inquiry was made. T 113-15. Moving to Patient C, Dr. Chen testified that Patient C was prescribed a controlled substance on a date when Respondent was out of the country and, therefore, undertook the prescription without having seen the patient and for which no PMP report was run. T 115-18. The same testimony was also given for Patient D and Patient E, each action testified to by Dr. Chen having been deemed by her to fall below the appropriate standard of care. T 118-23. Dr. Chen then expressed ongoing concern about the clarity of the records and cutting and pasting versus providing tailored notations for different visits. T 124-26.

On cross-examination, Respondent represented that Sana Behavior Health is a treatment facility or hospital of which he was the medical director and, therefore, his role was to oversee treatment of all patients. T 130-31, 134. It was also established that three of the five patients at issue were Respondent's patients. T 132-33; October 24, 2024 T 5. As to Patient D in particular, by reference to Exhibit 21, Dr. Chen testified that she attributed that patient's care to Respondent because Respondent was listed as the psychiatrist on the record and a prescription was written under Respondent's name (which patients were Respondent's was never sorted on the record). T 133-36. Dr. Chen testified that when the prescription for Patient D that is part of the record as Exhibit 20 was written, Respondent was out of the country and, therefore, someone else wrote the prescription and Dr. Chen assumes it was authorized by Respondent; however, under questioning she acknowledged that the pharmacist writes the physician's name and could have put the primary doctor as opposed to the physician that ordered the prescription. T 138-41. Dr. Chen then testified that she was assuming Respondent was the attending physician for Patient D and that if that was not the case and was the medical director then she "could see that being ok," referring to Respondent not being present to provide care given his role of overseeing patient care. October 24, 2024 T 6. With Respondent not having left to go out of the country until the evening of November 8, 2019, Dr. Chen also testified that the prescription for Patient B could have been issued by Respondent that day (T 7-8), and that her main concern with Patient A was Respondent's failure to run a PMP report and lack of appropriate record documentation but agreed that it was not appropriate for Respondent to run a PMP for a patient that was not his (T 9-10).

On redirect, Dr. Chen reiterated that to prescribe a controlled substance, a PMP report must be run by the prescriber and that the prescriber must see the patient. T 12-13. As to Patient B, looking at Exhibit 14, the attending physician for October 10, 2019 was Respondent and for November 8, 2019 was Debra Perkins and it was surmised that Respondent provided the prescription dated for November 8, 2019 on October 10, 2019, which is inconsistent with Respondent's statement in Exhibit 4 that he did not postdate the November 8, 2019 prescription. T 13-15.

On recross, Respondent established that Exhibit 17 was a written prescription that was undertaken while Respondent was out of the country and, therefore "had nothing to do with [Respondent]" and that Dr. Chen did not "have a problem with whatever role, if any, that [Respondent] played with respect to these exhibits [17, 20, and 25]," which Dr. Chen agreed with. T 17-18.

On final redirect, Dr. Chen reiterated the requirement for post-dating prescriptions at the time, that being that they had to have the date of the day they were undertaken and had to provide "do no fill" until a certain date with no more than three prescriptions from the same issuing date. T 19-20.

When the undersigned hearing officer attempted to clarify Dr. Chen's testimony with respect to whether it was appropriate that the called in prescriptions were attributed to Respondent even though he was out of the country when they were issued, Dr. Chen stated that it was appropriate because Respondent was the medical director. T 20-22.

Counts I-V

These are malpractice claims based upon several allegations, the first of which is that Respondent prescribed Patient A benzodiazepines while she was taking opioids. This was attributed to Respondent having failed, admittedly, to run a PMP report.

Exhibit 7 contains Patient A's medical records and Respondent is consistently listed as her attending physician from 2013 to 2019. As such, Patient A does not present a scenario where Respondent was covering for another provider or was unfamiliar with her prescription history. Thus, to the extent it was not refuted that Patient A should not have been prescribed

benzodiazepines while taking opioids, I recommend that Respondent be held accountable for this portion of this count.

The remaining basis of the malpractice claim is that Respondent prescribed controlled substances to Patients A through E while he was out of the country, without checking a PMP report, and without conducting corresponding examinations. As to Patient A, the record does not reflect, so far as undersigned has been able to determine, that Patient A was prescribed any controlled substances while Respondent was out of the country and without conducting corresponding examinations, although he did not run PMP reports in conjunction with prescribing controlled substances for other dates and should be held accountable for that reason. With respect to Patient B, it was determined that Respondent could have personally seen that patient to facilitate the prescription but, again, did not run the PMP report, for which he should be held accountable. As to Patients C, D, and E, those were Sana Behavioral Health patients and, per testimony, their prescriptions could have been appropriately linked to Respondent as the Medical Director and not necessarily as the attending physician, which Dr. Chen testified was not problematic.[3] The fact that the burden was not met as to those patients as to each of the counts (not just the malpractice counts) was somewhat conceded by the IC on the record. T 31-32. To the extent that what remains of this count is duplicative of what remains of counts XI-XVI as to Patients A and B, undersigned recommends that these violations be accounted for in the latter counts and not encompassed in allegations of malpractice.

Counts VI-X

These counts relate to patients A through E and are premised upon Respondent's failure to maintain complete medical records in that such records were lacking in relevant notations, reflected copying and pasting, etc. This was a consistent concern throughout each of the hearings and the state of the records was no different in relation to this matter. As such, Respondent should

[3] Undersigned was surprised to hear Dr. Chen testify, and even clarify when queried by undersigned, that prescriptions could be called in under Respondent's name as the facility Medical Director when he was not the physician who saw the patient or directed the prescription. I do not believe this to actually be accurate but that is what the record bore out and I have rendered this recommendation in accordance with the record and the testimony provided.

be held accountable for these counts in relation to Patients A and B (with the counts as to Patients C, D, and E being excluded for the reasons set forth above).

Counts XI-XVI

These counts are for violation of pharmacy regulations related to Respondent's admitted failure to run PMP reports in relation to Patients A through E. To the extent Respondent is responsible therefore in relation to Patients A and B, Respondent should be held accountable.

Counts XVII-XX

These counts are for fraudulent, illegal, unauthorized, or otherwise inappropriate prescribing of controlled substances for allegedly pre-signing prescriptions and would be relevant as to Patients C, D, and E. For the reasons set forth above, the burden of proof for these counts have not been satisfied.

Counts XXI-XXIV

These counts are based upon Respondent's statements in response to investigative inquires by the IC that he checks "the PMP regularly" and in relation to what he guessed may have taken place with regard to Patients C, D, and E. As noted elsewhere herein, undersigned does not interpret the conduct complained of as a violation of NRS 630.306(1)(b)(3), but which is presumably meant to refer to NRS 630.306(1)(b)(1), because undersigned does not interpret the statute to include conduct or statements made in response to an already pending IC investigation. The statute states that deceitful conduct "constitutes grounds for initiating disciplinary action." Given disciplinary action had already commenced by way of an opened investigation, I do not find that this conduct is actionable as pleaded. How I interpret that statute is that deceitful conduct can be the basis to open an investigation and subject a physician to subsequent consequences. That being said, there is no doubt that such misrepresentations support a lack of credibility and support related culpability.

Matter 3

This matter involves a patient with whom Respondent admittedly had a personal/sexual relationship and entails counts for malpractice; failure to maintain complete medical records; violation of statutes and regulations regarding the Nevada State Board of Pharmacy; unsafe or

unprofessional conduct; disreputable conduct; violation of a patient's trust and exploitation of physician/patient relationship for financial or personal gain; and fraudulent, illegal, unauthorized, or otherwise inappropriate prescribing of controlled substances.

The parties stipulated to the admission of exhibits 1-6, 10, and 11.

The IC's first witness was Ernesto Diaz, the Chief of Investigations for the IC who testified to having reviewed text messages between Respondent and the Patient dated February 2021 through June 2021.

The IC next called Darla Zarley, the administrator of the Prescription Monitoring Program, who testified that a prescribing physician is required to run a PMP report each time a controlled substance is prescribed and every 90 days thereafter. October 24, 2024 transcript, p. 29. Ms. Zarley also testified to Exhibits 4 and 5, which demonstrated that Respondent ran two PMP reports in relation to the Patient on March 18, 2022 as reflected in Exhibit 4 despite having prescribed controlled substances to her on several other occasions (Exhibit 5). T 27-29.

The IC then called Jayleen Chen, M.D., a psychiatrist who testified to her credentials and who further testified to the impropriety of having a romantic relationship with a patient. T 32-37. Dr. Chen expressed concern regarding medications being prescribed with no premise therefore being documented, high dosages, and failure to run PMP reports, as well as concern about Respondent's romantic relationship with the patient and incomplete records that were, at times, hard to follow and included inapplicable diagnosis and cutting and pasting. T 38-48.

Respondent testified that he was already dating the Patient when he began to treat her and admitted it was wrong for him to do so, indicating that the Patient then began to threaten and extort him, including threatening to report him to the Nevada States Board of Medical Examiners, and that he had been negatively financially impacted as a result of his relationship and the Patient's demands upon him. T 53-57.

Count I

This is a count for malpractice, a violation of NRS 630.301(4) and is based upon Respondent having treated the Patient while having a personal relationship with her; prescribing controlled substances without running corresponding PMP reports; and failing to justify in his

medical records a prescription for Ambien and a prescription for Adderall, which was overprescribed. These allegations have been substantiated and Respondent should be held accountable.

Count II

This count is premised upon failure to maintain accurate and complete medical records, a violation of NRS 630.3062(1)(a). Dr. Chen's testimony was that the records kept were insufficient and her testimony was not disputed. Respondent should be held accountable for such.

Count III

Count III is for violation of statutes and regulations of the Nevada State Pharmacy Board, a violation of NRS 630.306(1)(b)(3), and is premised upon Respondent's failure to run PMP reports, which was established and for which Respondent should be held accountable.

Count IV

This count is for unsafe or unprofessional conduct, a violation of NRS 630.306(1)(p), and is based upon the overprescribing of Adderall and engaging in a personal relationship with the Patient and/or prescribing her controlled substances. This conduct was established and unrefuted. Respondent should be held accountable accordingly.

Count V

Disreputable conduct as set forth in NRS 630.301(9) is conduct that brings the medical profession into disrepute, including, without limitation, conduct that violates any provision of a code of ethics adopted by the Board by regulation based on a national code of ethics. Having a sexual relationship with a patient is patently unethical and is a violation of the same statute, subsection (5), "engaging by a practitioner in any sexual activity with a patient who is currently being treated by the practitioner." While not charged under section 5, which is exactly on point, it remains that the same conduct brings the medical profession into disrepute and is a violation for which Respondent should be held accountable.

Count VI

Count VI is for violation of patient trust and exploitation of the physician and patient relationship for financial or personal gain, a violation of NRS 630.301(7). Respondent's position

was that he was the victim of exploitation at the hands of the Patient in that the Patient utilized their relationship to exploit Respondent for financial gain; however, it cannot be overlooked that it was Respondent that put himself into that position for personal gain – that being the benefits of an ongoing personal/sexual relationship. Regardless of the fact that Respondent may have already been dating the Patient when he started treating her, her reliance upon him for medications and/or treatment that then becomes tied to an ongoing sexual relationship is exploitive, cannot be condoned, and was unequivocally a breach of trust regardless of any unfavorable actions the Patient may have responded with.

Count VII

The final count is for the fraudulent, illegal, unauthorized or otherwise inappropriate prescribing of controlled substances, a violation of NRS 630.3062(1)(h). Prescribing controlled substances to a patient without whom Respondent was personally involved was inappropriate and Respondent should be held accountable accordingly.

Matter 5

Matter 5 was dismissed by and through an Order for Dismissal With Prejudice, filed on October 29, 2024, and signed by Brett W. Frey, M.D., Chair of the IC.

BASED UPON THE FOREGOING, in summary, it is recommended that Respondent be held accountable for the following:

Matter 1: Counts I-LXVI;
Counts LXVII-LXXIX;
Counts LXXX-CXXXVI;
Counts CXCVIII-CCIV; and
Counts CCV-CCXI

Matter 2: One count of Counts I-V for prescribing benzodiazepines to Patient A while she was prescribed opioids;
Two counts of Counts VI-X for the medical records related to Patients A and B;

Two counts of Counts XI-XVI for failing to run PMP reports as to Patients A and B;

Matter 3: All Counts

Matter 4: Counts II, IV, V, and VI;

Matter 5: Dismissed

RESPECTFULLY SUBMITTED this 19th day of May 2025.

Patricia Halstead, Esq.,
Hearing Officer
615 S. Arlington Ave.
Reno, NV 89509
(775) 322-2244
phalstead@halsteadlawoffices.com

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 19th day of May, 2025, I served a file-stamped copy of the foregoing **FINDINGS AND RECOMMENDATIONS**, via USPS Certified Mail, postage pre-paid, to the following parties:

MATTHEW OBIM OKEKE, M.D.
c/o Liborius Agwara
LAW OFFICES of LIBO AGWARA, LTD
2785 E. Desert Inn Rd., Ste 270
Las Vegas, NV, 89121

Tracking N 9489 0178 9820 3037 2108 67

With courtesy copy by email to:

Liborius Agwara, Esq., at libolaw@yahoo.com

DATED this 19th day of May, 2025.

Valerie Jenkins
VALERIE JENKINS
Legal Assistant
Nevada State Board of Medical Examiners

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BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

FILED

NOV 12 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

In the Matter of the Charges and Complaint Against:
MATTHEW OBIM OKEKE, M.D.,
Respondent.
_____/

Case No. 24-22461-2

TRANSCRIPT OF HEARING PROCEEDINGS

Held via Zoom

Wednesday, October 23, 2024

Reported by: Brandi Ann Vianney Smith
Job Number: 6727899

A P P E A R A N C E S:

THE HEARING OFFICER:	PATRICIA HALSTEAD, ESQ.
FOR THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS:	SARAH BRADLEY, ESQ. Deputy Executive Director Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, NV 89521
FOR RESPONDENT:	LIBORIUS AGWARA, ESQ. Law Offices of Libo Agwara Ltd. 2785 E. Desert Inn Road, Ste. 280 Las Vegas, NV 89121

ALSO PRESENT:
Valerie Jenkins, Legal Assistant

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EXHIBITS

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RENO, NEVADA -- OCTOBER 23, 2024 -- 9:40 A.M.

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HEARING OFFICER HEALSTEAD: We're on the record in case number 24-22461-2, In the Matter of the Charges and Complaint Against Matthew Obim Okeke, M.D., respondent. We're proceeding on the First Amended Complaint that was filed on June 27, 2024.

I'm the Hearing Officer assigned to this case, Patricia Halstead. This matter is being conducted remotely by the Zoom app, as commenced by the Medical Board. Present are Sarah Bradley on behalf of the IC. Dr. Okeke is here represented by Liborius Agwara. This matter is being recorded and everyone consents to the Zoom appearances.

I'll start with you, Ms. Bradley. Please state your appearance for the record.

MS. BRADLEY: Sarah Bradley, Deputy Executive Director of on behalf of the Investigative Committee.

HEARING OFFICER HEALSTEAD: Thank you.

Mr. Agwara, can you state your appearance and note your client's appearance.

MR. AGWARA: Liborius Agwara for the respondent, Dr. Okeke, who is also present.

HEARING OFFICER HEALSTEAD: Okay. And are there any procedural matters we need to address before we commence with opening statements? I know there was time taken to address exhibits.

MS. BRADLEY: Yes. I'm ready to put stipulations on the record.

HEARING OFFICER HALSTEAD: Yes, please.

MS. BRADLEY: In first thing we stipulated to was fact 42 in the Complaint, it's on page 8. We're stipulating to truth of that fact as long as we add 11:45 p.m. on November 8, 2019. He left the country on a flight that left at 11:45 p.m. on November 8, 2019.

HEARING OFFICER HEALSTEAD: Eleven?

MS. BRADLEY: 11:45 p.m., November 8, 2019, is actually when he left the country.

HEARING OFFICER HEALSTEAD: That was the time his flight left?

MS. BRADLEY: Yes.

HEARING OFFICER HEALSTEAD: Okay.

MS. BRADLEY: And based on that, the Investigative Committee will strike fact 48 because fact 48 says that he was out of the country on

November 8, 2019, but he didn't leave until after hours that day.

HEARING OFFICER HEALSTEAD: Okay.

MS. BRADLEY: Then with regard to the exhibits, we have stipulated to the admission of 1 through 4. The IC is withdrawing number 5, based on the stipulation of when he was out of the country.

HEARING OFFICER HALSTEAD: Um-hum.

MS. BRADLEY: We have stipulated to admit 6 through 12. We're removing 13 because we don't need it. We are admitting 14 through 20 by stipulation. We are going to lay some foundation for 21 to get that admitted. 22, we are withdrawing.

We are stipulating to 23 through 25, and again we're going to lay some foundation regarding 26. We're removing 27. And then stipulating to 28 and 29.

We will admit 30, 31, and 32 with Dr. Chen, with little bit of foundation from Mr. Diaz, but mostly with Dr. Chen.

HEARING OFFICER HEALSTEAD: Is that correct, Mr. Agwara?

MR. AGWARA: Yes, that is correct.

HEARING OFFICER HEALSTEAD: Exhibits 1

through 4 will be admitted.

(The Board's Exhibits 1 through 4 were admitted.)

HEARING OFFICER HALSTEAD: Exhibit 5 is withdrawn. Exhibit 6 through 12 will be admitted.

(The Board's Exhibits 6 through 12 were admitted.)

HEARING OFFICER HALSTEAD: Exhibit 13 is withdrawn. Exhibits 14 through 20 are admitted.

(The Board's Exhibits 14 through 20 are admitted.)

HEARING OFFICER HALSTEAD: 21 will remain subject to admission. Exhibits 22 is withdrawn. Exhibits 23 through 25 are admitted.

(The Board's Exhibits 23 through 25 are admitted.)

HEARING OFFICER HALSTEAD: Exhibit 26 will remain subject to admission. 27 will be withdrawn. Exhibits 28 through 29 will be admitted by stipulation.

(The Board's Exhibits 28 and 29 were admitted.)

HEARING OFFICER HALSTEAD: And Exhibits 30 through 32 will be subject to admission.

Did I recite that correctly?

MS. BRADLEY: Yes, you I did.

MR. AGWARA: Yes.

HEARING OFFICER HEALSTEAD: Is there anything further before we commence with opening statements?

MS. BRADLEY: No.

MR. AGWARA: No.

HEARING OFFICER HEALSTEAD: Okay.

Ms. Bradley?

OPENING STATEMENT

MS. BRADLEY: This case is regarding Dr. Okeke's treatment of five patients, Patients A, B, C, D, and E. Primarily most of the time on this case is going to be spent regarding Patient A. Patient A had extensive treatment history with Dr. Okeke, and we have concerns regarding the treatment that was provided.

Specifically, Dr. Okeke did not query the prescribing utilization report for Patient A, and he also was prescribing benzodiazepines to Patient A while the patient was receiving opioids from another provider.

We have concern that, number one, the query was not done, and, number two, not doing that query put the patient at risk for respiratory

depression and other negative affects due to the co-use of opioids and benzodiazepines at the same time.

We also have concerns regarding the records for Patient A. The medications listed as current medications are very confusing, showing multiple doses and multiple types of medicines. Mostly likely they are not accurate in the medical records.

Primarily the focus we will have is 2018 treatment. It's our understanding that Dr. Okeke actually treated this patient from approximately 2014 to 2019, and most of what we are talking about here is treatment in 2018.

We are concerned that the medical records are not clear, legible, accurate, and complete, and, in fact, would have been confusing to any other provider looking at this case and perhaps Dr. Okeke himself, given that we know it's not abnormal for a psychiatrist to have multiple patients, and so that's why it's so important for the records to be accurate.

There's also some treatment dates for seven months in 2019. So I believe we're going to talk about all of 2018, and then 2019, the first

eight visits. It's approximately 20 visits that this Complaint is going to be concerned with regarding Patient A.

So, again, there's concerns regarding the co-use of benzodiazepine such clonazepam and alprazolam with opioids that this patient was receiving from another provider. We believe that Dr. Okeke knew or should have known that the patient was being prescribed those opioids, and he should have addressed that in his records and noted that he had a conversation with her about that and highlighted the concerning -- that that was concerning.

The source of this complaint -- I just say this for background -- was a concerned family member regarding the amounts of drugs that this patient was taking.

There's also some discrepancies regarding medications that are being shown for a really long time period. I know we've had testimony regarding the system that Dr. Okeke uses, but the Board is still concerned that, for example, there's three different strengths of Adderall listed, an antibiotic that's listed as being taken from January 2018 to July 2019. There's just things that

make it hard for anyone who would review these records and take over care to even know what the patient is taking.

One of the problems with that is the patient, then, has to tell the provider what they're taking, and patients don't always know. Right? Patients don't always remember, they are not great historians regarding their own medications. And so it's helpful when the medical records are accurate so that they can show the accurate picture for the patient.

There's concerns regarding copy and pasting progress notes from visit to visit for Patient A, which Dr. Chen will testify it is not according to the standard of care.

She also will testify that she believes that Dr. Okeke did not show the level of diligence that the standard of care requires regarding documentation, review, and management of Patient A's medications, and that fell below the standard of care.

In his response to the Board regarding this case, Dr. Okeke said, "I checked the PMP regularly." However, if that was true, Dr. Okeke should have known the patient was also taking

opioids while he was prescribing benzodiazepines to her, but the record actually will, when we get the evidence, show that he did not conduct a query of the patient regarding her prescribing history at any time from January 28 to July 2019.

He did query it around the time that he received the Board's letter in this case. I think in connection with his response there is a query, but it was not done during the time period at issue, and therefore it wasn't utilized to make medical decisions regarding her care.

The quantities of controlled substances that were prescribed to Patient A by respondent, at least according to the medical records, they do not always match what's showing in the PMP report. So the PMP report shows what the prescriptions were for and what were filled at the pharmacy, and the quantities are not always the same. And so, again, that's a concern we have regarding documentation in her medical records because it should have been accurate.

Sometimes Dr. Okeke provided Patient A with prescriptions that were more than a 30-day supply, but he saw her almost exactly every 30 days. He saw her monthly. But there are times, that Dr.

Chen will address, where he provided her with more than a 30-day supply.

Those are the concerns regarding Patient A.

Regarding Patient B, the concern here is that Dr. Okeke gave Patient B a prescription. Now the prescription was provided on November 8, 2019, and based on the stipulation between the parties, Dr. Okeke, we believe, probably worked that day. I think his testimony will be that he worked in the office that day, but we, in the medical records for Patient B, do not have a visit that correlates with that date.

And Dr. Chen will talk about the fact that when you provide a prescription for a controlled substance, there needs to be a progress note, there needs to be a visit in conjunction with that prescription.

And so he left late that night to go out of the country, but still the prescription that was provided to the patient that was dated for November 8, 2019, is concerning to the Board, and we believe it falls below the standard of care to provide that prescription without seeing the patient.

He does say in response to an allegation

letter regarding this case -- regarding this patient, he said that he saw the patient on October 10, 2019, and then that patient saw someone else on November 15, 2019. Perhaps that's why there's no note from Dr. Okeke, but that would also mean, then, that Dr. Okeke did not see the patient on November 8th, which I think proves the concern that we have that a prescription was provided with a date that he did not see the patient.

We have alleged that we believe there could have been -- that could have been a pre-signed or postdated prescription, but it was not noted appropriately that it was such a prescription. It did not say the date that it was provided, which likely would have been October 10, 2019, and it didn't have a "do not fill" phrasing on there for the date that it should be filled.

Another concern we have regarding Patient B is that Dr. Okeke was providing controlled substances to him and did not query his PMP history until February 2020. Actually, the date was two days after the letter from the Board.

The Board sent two letters in this case. The first one was regarding Patient A, then later the Board sent a letter to him asking additional

questions regarding Patient A, and then adding Patients B, D, D, and E.

Two days after the date of that letter is when the first query was done for Patient B. So it wasn't done according to time that he was prescribing and treating; it was just done too late.

Dr. Chen will testify that Patient B received a refill for Valium too early. Again, when prescribing controlled substances, she will talk about that the standard of care is to ensure that those medications are refilled in a timely manner. One of the concerns about prescribing too early is that a person can abuse the medication or could end up with extra. They are supposed to be taking them as prescribed, and they should have the right amounts at the right times. The patient utilization report from Patient B shows that he received a refill for Valium too early. Specifically, he got a 30-day supply on April 11, 2019, another 30-day supply on April 24, 2019, and a 30-day supply on May 9, 2019. According to the PMP, all three of these prescriptions in addition to others for Patient B were written by respondent.

Regarding Patient C, we have a concern regarding a prescription that was written for

Patient C that has Dr. Okeke's name on it. This prescription was written on November 27, 2019, and we do not believe that Dr. Okeke saw the patient on that day prior to giving him the prescription. There's no medical record that supports that, and that is a date that Dr. Okeke was out of the country.

Dr. Okeke said to the Board investigator that he's never seen this patient in any setting that I can remember. I did not give him any prescription. I do not have a record of seeing or treating him. However, prescribing was done for this patient under his name, under Dr. Okeke's name.

We believe that Dr. Okeke allowed another person in his office to either sign his name to the prescription or he pre-signed the prescription for Patient C prior to leaving the country. And the PMP records show that there was also not a query done for Patient C by Dr. Okeke until February of 2020. Again, in connection with the Board's letter regarding Patient C.

The other concern we have is if Patient C was not a patient of his, he should not have queried the PMP. I mean, I realize he may have been doing it to see what happened, but he should query his own

history because he is to query his history to see what's being done, but he is not to query people that are not his patients. And so it would have been a violation of law -- if this person wasn't his patient, it's a violation of law to actually check his PMP.

Patient D is very similar to Patient C. It's the same date. There's a prescription written on November 27, 2019. That is a date that he was out of the country. And we believe that Dr. Okeke did not see patient D.

I again note, though, that -- and it's similar to C, it's written on there, it doesn't look like his signature from Dr. Okeke on that prescription. Dr. Chen will talk about that with regard to these. It's our understanding that these can be called in by the provider, but they are to have a person's name written on there and then the initials or the name of the person who did the calling in. And that's what seemed to happen in C and D with Dr. Okeke's name on them.

Regarding Patient D, Dr. Okeke's name is signed in on a meeting. It was a day before the prescription, there was a meeting at Sana Behavioral Health regarding Patient D, and his name is signed

on an interdisciplinary Team meeting, but, again, we believe he was out of the country on that day and that Patient D was actually seen by an APRN while at Sana.

Upon information and belief, we think that he did not examine Patient D on November 27, prior to giving her the prescription, which is a violation of the standard of care. And delegating signatory approval is not allowed unless -- he can't have someone else do it on his behalf. He can if it's -- I think it's a Schedule 3 or 4, he can allow someone else to call it in, but they have to do it at his direction.

Upon information and belief, we believe that he either signed his name to the prescription prior to going out of the country or told someone else to do it while he was out of the country, again, without seeing the patient.

Finally, we have Patient E. Again, it's very similar, however, it's a different day. We have a prescription for Patient E for Klonopin on November 15, 2019. Respondent is referenced in some documents. Dr. Okeke is referenced in some documents as the attending physician for Patient E during her stay at Sana.

The concerning part here is that the prescription that was written on November 15, if we look at her report, there's another prescription for the same medication from an APRN on that same day. So we're not sure why or how, but Dr. Okeke's name was used while he was out of the country to write this prescription for her, and she got two, which is concerning.

Sana records support that this patient was actually seen by other providers while Dr. Okeke was out of country. We're not sure how his name ended up in her treatment as well, and his name is prescribing to her.

PMP records do not show that Dr. Okeke did any queries of Patient E's prescribing history in the time period that was required by law. I don't have a note here, I don't think he checked her on February 20 like the others when he was responding. I think he just did not query her at all, if I remember correctly.

In response to the Board investigator regarding Patients D and E, Dr. Okeke concedes that he traveled on the days that the prescriptions were provided, and says that he would guess that someone used his name to fill a prescription and did not

authorize the prescription in any way.

However, the Board has received no information that the use of his prescribing credentials was compromised. There's a process for that. Generally, the licensee should contact the Board of Pharmacy, and then also contact law enforcement. We have no information that that was done.

If his credentials and/or name were used to fraudulently fill a prescription, he didn't follow the protocol to report that.

We also are concerned that Dr. Okeke did not query his own prescribing history at least once every six months, which is required by Nevada law. Part of the reason for that requirement is to allow licensees to detect unauthorized prescribing.

So we believe that if he had queried his prescribing history every six months as the law requires, that he would have noticed these unauthorized prescriptions sooner. And -- if they are unauthorized, that is -- he also could have reported that or should have reported that.

We believe that those facts will prove five counts of malpractice, five counts of failure to maintain complete medical records, five counts of

failing to query the PMP in violation of statutes and regulations of the Nevada State Board of Pharmacy. I believe it's just four counts of fraudulent prescriptions for B, C, D, and E. And then engaging in conduct which is intended to deceive by telling the Board in response to the letters that he checks the PMP regularly and that he didn't authorize prescriptions that we believe he did. We believe that's conduct intended to deceive in connection with the investigation, and we believe that is what the evidence and testimony will prove.

Thank you.

HEARING OFFICER HEALSTEAD: Thank you, Ms. Bradley.

Mr. Agwara?

MR. AGWARA: Thank you.

OPENING STATEMENT

Normally I would waive the opening, but I need to provide some, I guess, guidance in terms of -- in particular with regard to some of the patients.

Ms. Bradley talked about Sana patients. If my understanding is correct, those patients are hospital patients. They were hospital patients who were seen. And my understanding and my client will

testify to this is that when you're seeing a patient that's not yours, you can't change -- I mean, I don't know if you can or not, but the rules are different.

The testimonies will show that there's a lot of my understanding in terms of the context under which a lot of his patients were seen. If they are hospital patients and my client is not there, what they are going to do when they order and when they issue the prescriptions, it is the medical director's name that will be put on there. As you will see, as a matter of fact there's one, these are handwritten, no signature of my client, somebody just filled his name. Another provider's name was actually put on one of them. I don't remember exactly which patient that is. And the name they put, I understand, is the actual provider that saw them, but they crossed it out and put Dr. Okeke's name because he was the medical director for the either the hospital or the establishment. That's what the evidence is going to show.

Now, the issue of PMP, here we go again, this is 2019 to 2020. I believe Ms. Zarley in the previous case testified that Dr. Okeke had applied sometime around September of 2019 for the

integration, the integration of the PMP with his EMR. For some reason, I guess the approval didn't come until the following year, 2020. So, I guess, we'll have to find out, especially with Patient A, which if I recall, is the only prescription that has a signature that looks like his.

So with that, let's just get to the testimonies. I think usually the closing statements are more important than these opening statements, because usually we will get -- the evidence doesn't bear out a lot of claims made in the opening statements.

With that, we're ready to start.

HEARING OFFICER HEALSTEAD: Thank you, Mr. Agwara.

Ms. Bradley, do you want to call your first witness?

MS. BRADLEY: Yes. Let me text him to join us.

(The witness joined the hearing.)

HEARING OFFICER HALSTEAD: I can swear him in, and then you can formally call him.

(The oath was administered.)

DIRECT EXAMINATION

BY MS. BRADLEY:

Q. Mr. Diaz, would you please state your name and spell your last name for the record?

A. Ernesto Diaz, D-I-A-Z.

Q. Who is your employer?

A. Nevada State Board of Medical Examiners.

Q. What is your job title?

A. Chief of Investigations.

Q. How long have you had that position?

A. Approximately four years and eight months.

Q. Do you have any other investigations experience?

A. Yes. I was a U.S. Border Patrol agent for four years and an ATF agent for 21 years.

Q. And the chief of investigations for the Nevada State Board of Medical Examiners, what are your duties?

A. I supervise two deputy chiefs, seven investigators, two medical reviewers for the investigations division. I review complaints that come forth to the Medical Board for jurisdiction. If a case falls within our jurisdiction, an investigation is opened.

Q. Okay. Do you also investigate cases

yourself?

A. Yes.

Q. When a complaint comes in, what happens?

A. Complaint is reviewed. If an investigation is opened, a case file is created. It's assigned to an investigator and an investigative committee.

Q. And when it's opened, does the Board created a file for that matter?

A. Yes, we do.

Q. Are you familiar with an investigation that has a file number of 19-19115?

A. Yes, I am.

Q. And that's regarding Dr. Matthew Okeke?

A. Yes, it is.

Q. Were you the original investigator in this case?

A. No, I was not.

Q. Do you know who was?

A. Yes. It was senior investigator Kim Friedman, F-R-I-E-D-M-A-N.

Q. As the chief of investigations, what do you do with cases after an investigator is no longer employed by the Board?

A. The cases are reassigned to myself or one

of the two deputy chiefs.

Q. Did you take over this case?

A. Yes.

Q. As the chief of investigations, are you familiar with the procedure used by the Board when investigating cases?

A. Yes, I am.

Q. Have you reviewed the file for this case?

A. I have.

Q. Based on your review, does this case appear to be similar to other investigations handled by the Board?

A. Yes.

Q. Okay. Most of our exhibits have been admitted. I do want to ask you about what's been premarked as the Board's Exhibit 21.

Do you recognize these documents?

A. Yes, I do.

Q. What are they?

A. They are medical records from Sana Behavioral Health.

Q. How did the Board receive these records?

A. Investigator Friedman has sent a subpoena to get patient records in this investigation.

Q. Okay. And this one of records we received

in response to that subpoena?

A. Yes, it is.

Q. And is that part of the Board's process to receive --

A. Yes.

Q. -- from outside entities?

A. Yes, it is.

Q. Are these a true and correct of the records received from Sana Behavioral Health, Patient D, in connection with the investigation in this matter and maintained in the Board's file for this matter?

A. Yes, for Patient D.

Q. And just for the record, do you know the dates the subpoenas were sent by Ms. Friedman to Sana Behavioral Health?

A. Yes. She sent two. One was March 12, 2020, that was for, I believe, four patients. And then she sent another one for a different patient, July 20, 2020.

Q. Okay.

MS. BRADLEY: Based on Mr. Diaz's testimony, I would ask that Exhibit 21 be admitted into evidence.

HEARING OFFICER HEALSTEAD: Mr. Agwara?

MR. AGWARA: Well, I mean, I was hoping I'll cross before she moves for admission. Which one do you want me to do, object to the admission or cross?

HEARING OFFICER HEALSTEAD: I'm asking you if you object to the admission.

MR. AGWARA: Yes.

HEARING OFFICER HEALSTEAD: Okay. What's the basis of your objection?

MR. AGWARA: Is there a reason why we don't have a copy of the subpoena? Especially since he wasn't the one that sent it.

HEARING OFFICER HEALSTEAD: Okay. So the basis of your objection is that a copy of the subpoena hasn't been provided?

MR. AGWARA: He cannot authenticate. He's just saying the subpoena was sent. Now, in these hearings when they send you a subpoena, they always identify the subpoena as a separate exhibit. We don't have that in this case, and there is no custodian of records affidavit or statement or anything.

HEARING OFFICER HEALSTEAD: Ms. Bradley, do you want to respond to that?

MS. BRADLEY: I would respond that

Mr. Diaz has testified that he's reviewed the file, reviewed the product that was completed by the prior investigator who has this case. He's reviewed the subpoenas that she sent out, he's sees that this was sent to the Board in response, and it's part of the Board's file for this case.

We believe it's admissible.

HEARING OFFICER HEALSTEAD: Okay. And when you guys send a subpoena, do you not get affidavits of custodian of records? I only ask because -- I know formal rules of evidence don't apply, but I'm just wondering if that's something you guys request and get with records requests?

MS. BRADLEY: I believe we do normally ask for those. I believe we do normally get those. In this case, I know the exhibits that we have before doesn't include it. I don't recall whether I saw one or not in the file.

HEARING OFFICER HEALSTEAD: And, Mr. Diaz, are you looking for one?

THE WITNESS: Yes, ma'am. I'm looking for the corresponding certificate of custodian of records for those subpoenas that were sent out to Sana Behavioral Health.

HEARING OFFICER HEALSTEAD: Okay. Let us

know when you've finished looking.

THE WITNESS: Yes, ma'am.

HEARING OFFICER HEALSTEAD: While he's looking, Ms. Bradley, can you proffer what these records -- what the reliance on these records is going to be based on?

THE WITNESS: I did find one, ma'am, if I could read the name of the individual that notarized it?

HEARING OFFICER HEALSTEAD: Okay. Just a moment. Let me finish with Ms. Bradley.

MS. BRADLEY: Okay. What we intend to rely on is these records show some involvement of Dr. Okeke in Patient D's care. And then it also shows involvement by others.

Again, I think the concern we have is that a prescription was written, using his name at least, for this patient on a date when he's out of the country. If he wrote that or authorized it to be written, that violates the law.

HEARING OFFICER HEALSTEAD: So what do these records show in relation to that?

MS. BRADLEY: These records show his name on an interdisciplinary Team meeting note dated November 26, 2019. They also show that there is no

record in these of him examining the patient prior to the prescription that was written in his name for the patient.

HEARING OFFICER HEALSTEAD: Okay. Is this clinic a clinic that he was affiliated with?

MS. BRADLEY: I believe that his counsel said in his opening that he was the medical director of Sana Behavioral Health at the time of this complaint or these incidents.

HEARING OFFICER HEALSTEAD: Okay.

Mr. Diaz, you said you found an affidavit of the custodian of record?

THE WITNESS: Yes, ma'am.

HEARING OFFICER HEALSTEAD: For which subpoena -- or for which documents?

THE WITNESS: It's dated March 20, 2020, by the custodian of records for Sana Behavioral Health. Kathy Kershaw, K-E-R-S-H-A-W.

HEARING OFFICER HEALSTEAD: Okay. But you said there were two subpoenas, so which documents does that affidavit of custodian support?

THE WITNESS: This one was for -- can I read the patient designations, would that help?

HEARING OFFICER HEALSTEAD: I don't know that we want the patient's name on the record.

THE WITNESS: Well, it's three patients. This subpoena was sent March 12, 2020.

HEARING OFFICER HALSTEAD: Then what about -- and so that would be, Ms. Bradley, which patients would that be?

MS. BRADLEY: Well, Mr. Diaz can you look at your patient designation list and see if Patient D is one of ones listed in that? I'm looking at it, the initials are RL, I don't know if that relates to that response.

THE WITNESS: Yes. The request for orders sent March 12, 2020, did include Patient D.

MR. AGWARA: Can I make a suggestion? I mean, I don't know if we can -- I guess this is Ms. Halstead's decision to make. I have never had one of these where the custodian of records affidavit is being weighed in instead of being provided as part of the record.

If they want to take the time and email this to us and to the Hearing Officer, I think that would be the best way to go, but that's up to Ms. Bradley.

HEARING OFFICER HEALSTEAD: My suggestion is going to be print it out and supplement it in the record. But it's sounds like it applies to the

patient that Ms. Bradley's records respond to and that she wants to use them for.

That was going to be my suggestion that it be printed out and supplemented as an exhibit.

MS. BRADLEY: We're glad to do that.

HEARING OFFICER HEALSTEAD: Okay. Does that work for you, Mr. Agwara?

MR. AGWARA: That will be after the fact. What happens if it doesn't jibe with the records in that case? I think it will be safer for her case. I mean, it's up to her. Whatever she wants to do, if that's okay with you, Ms. Halstead, that's fine. I still maintain my objection.

HEARING OFFICER HEALSTEAD: Okay.

Mr. Diaz, can you -- is there an affidavit of custodian records for the second subpoena?

THE WITNESS: I cannot locate one, but I believe those were received by email. I can provide you -- it was only for one patient, and it asked for employment/employee information. I did not see one of those for that other request.

HEARING OFFICER HEALSTEAD: Okay. The records in Exhibit 21, you're representing that these are from the first subpoena and are titled within the affidavit of the custodian of records?

THE WITNESS: Yes, ma'am. Sent on March 12, 2020.

HEARING OFFICER HALSTEAD: Okay. So with that representation, I'm going to admit Exhibit 21, but I'm going to require that the affidavit of custodian of records be supplemented as Exhibit 33 for admission.

(The Board's Exhibit 21 was admitted.)

THE WITNESS: Yes, ma'am.

HEARING OFFICER HEALSTEAD: And Ms. Bradley, you can file that when you file the amended complaint in the other matter.

MS. BRADLEY: Okay. Should I continue with Mr. Diaz?

HEARING OFFICER HALSTEAD: Yes, please.

BY MS. BRADLEY:

Q. Mr. Diaz, would you please turn to Exhibit 26. These records are for Patient E. We just talked about Sana.

Can you confirm whether or not records for Patient E are also included on that custodian of records affidavit that you just talked about?

A. That is correct. Those records include Patient E.

Q. So for the record, you do recognize

Exhibit 26?

A. Yes.

Q. And what are these?

A. These are healthcare records from Sana Behavioral Health for Patient E.

Q. How did the Board receive these documents?

A. These were received pursuant to the request for records sent out by the investigator on March 12, 2020.

Q. Are these true and correct copies of Patient E's records that were received from Sana Behavioral Health in connection with the Board's investigation and maintained in the Board's file for this matter?

A. Yes.

MS. BRADLEY: Based on Mr. Diaz's testimony, I would ask that Exhibit 26 be admitted, and we also include that affidavit of custodian of records with regard to Exhibit 26.

HEARING OFFICER HALSTEAD: Mr. Agwara?

MR. AGWARA: I would object. The same objection. It lacks authenticity, it has not been authenticated, and there's no custodian of records affidavit.

HEARING OFFICER HEALSTEAD: Okay. So I

will admit them based on the same requirements based on the testimony and the affidavit of the custodian of records, will likewise be --

(The Board's Exhibit 26 was admitted.)

MR. AGWARA: I believe Mr. Diaz said he can't see one for this particular set of records, couldn't see an affidavit.

MS. BRADLEY: That's not what he said. What he said was there was two subpoenas sent, one requested four patient records. He testified earlier that Patient D's records were included in that request and that response.

And just now, he testified that Patient E's records were included in that subpoena and that response. And so the affidavit of custodian of records that he talked about a few minutes ago applies to both patients, D and E.

HEARING OFFICER HEALSTEAD: And that was my understanding and the basis for my ruling, corresponding to the prior billing.

MR. AGWARA: Let me make sure I'm clear: I have testimony regarding belief that what was sent by email or something and they couldn't locate it right now.

HEARING OFFICER HEALSTEAD: No. So what

he testified and what I understood was the patient that these records in Exhibit 26 relate to fell within the first subpoena for which the affidavit of custodian corresponds.

MR. AGWARA: Okay. So what happens -- was there a second subpoena?

HEARING OFFICER HEALSTEAD: Yes. Let's clarify that, Ms. Bradley or Mr. Diaz, whoever wants to respond to that, what patient did the second subpoena correspond to?

THE WITNESS: There is no designation for this patient in the list I've been provided.

MS. BRADLEY: I believe what he said was the response to the second subpoena had to do with employment records at Sana Behavioral Health, so -- and I'm not looking at documents.

MR. AGWARA: He didn't say that.

MS. BRADLEY: He did say that.

HEARING OFFICER HEALSTEAD: Okay. I don't want any arguing back and forth. Mr. Diaz can clarify that if need be.

THE WITNESS: Yes, ma'am. The second request sent in July 20, 2020, was for employee records for Sana Behavioral Health or any other healthcare provider that treated a certain patient

who is not on the designated list.

HEARING OFFICER HEALSTEAD: Okay. Are we going to be dealing with the records from the second subpoena, Ms. Bradley?

MS. BRADLEY: No.

HEARING OFFICER HEALSTEAD: Okay. All right. My ruling stands. Please continue.

BY MS. BRADLEY:

Q. Mr. Diaz, would you please turn to Exhibit 30.

Do you recognize -- oh, and 31, 30 and 31 both. Do you recognize these documents?

A. Yes, I do.

Q. What are they?

A. These are documents that were provided as part of the peer review that was conducted in this investigation.

Q. Are these documents that the reviewer indicated that she relied on in her opinion?

A. Yes, they are.

Q. Is it unusual for a peer reviewer to provide such documents to the Board?

A. No, it's not. We actually request that they provide us any research or documents that they used in the production of their report.

Q. Do these appear to be a true and correct copy of the articles received from the Board's peer reviewer after she completed her medical review of this case?

A. Yes.

Q. Lets now turn to what has been premarked as the Board's Exhibit 32.

Do you recognize this document?

A. Yes, I do.

Q. What is it?

A. It's a CV of the peer reviewer that was utilized in this investigation.

Q. How did the Board receive it?

A. From the peer reviewer.

Q. Does itappear to be a true and correct of Dr. Chen's curricula vitae as received by the Board?

A. Yes, it does.

Q. Mr. Diaz, would you please turn to Exhibit 4.

MR. AGWARA: That was already admitted.

MS. BRADLEY: I know it's already admitted. I have questions for him about it.

MR. AGWARA: Okay.

BY MS. BRADLEY:

Q. Could you look at notes for -- or the

response -- okay. First of all, just for the record, what is Exhibit 4?

A. It is a response from Dr. Okeke to the allegation letter that was sent by the investigator in this case.

Q. Okay. So would you look at the notes for the response for, it says number 3, number 4, and number 5?

A. Yes.

Q. You see those.

Can you read that sentence that starts with "I did not"? The same sentence was repeated in 3, 4, and 5.

A. "I did not authorize the prescription in any way. The medical records are with the hospital."

Q. Do you see that -- please continue with number 3.

A. "I have never authorized Dr. Victor Bruce to write any prescription to any patient. We discussed the scope of his license and he understands his limitations. He has never brought a patient to me to write a controlled substance for him."

Q. Then if you look at number 4 and number 5,

does it also say, "I did not authorize the prescription in any way for those two patients"?

A. Yes, it does.

Q. And did you see the part of the sentence that starts with "I would guess"?

A. For which number?

Q. I think it's for 3, 4, and 5.

A. Yes, ma'am. "I would guess that they used my name to fill a prescription."

Q. So as part of your duties as chief of investigations, do you become aware of instances where a prescriber has their prescribing credentials compromised?

A. Yes. I have personally received phone calls from medical doctors calling to inform the Board that they thought either prescription pads were stolen or being misused. I would refer them to the Pharmacy Board to notify them, because there is a process that the pharmacy utilizes once they are notified of possible fraudulent or theft of prescription, and I also recommend that they contact law enforcement.

Q. And if the Pharmacy Board receives a report like the prescribing credentials were compromised, what does the Pharmacy Board do with

that, if you know?

MR. AGWARA: Objection. Goes beyond the scope of this witness' skills and expertise of the testimony. He works for the Medical Board not the Pharmacy Board.

HEARING OFFICER HEALSTEAD: Can you repeat the question, Ms. Bradley?

BY MS. BRADLEY:

Q. What does the Pharmacy Board do with a report that a prescribing -- a prescriber's credentials have been compromised, if you know?

A. May I answer the question?

HEARING OFFICER HEALSTEAD: Given that it was based on your knowledge and you're an investigator familiar with other procedures from a similar board, then yes.

THE WITNESS: What the Pharmacy Board does is they send out a notification to the pharmacies in the State of Nevada basically notifying them not to fill the prescriptions for this particular registration for a period of time.

They also send notification to the Nevada State Board of Medical Examiners notifying our board that this particular medical doctor's prescribing registration has been compromised. We do get

notified by the Pharmacy Board of that.

BY MS. BRADLEY:

Q. Is that, I guess I would say, a more official notification than when a licensee calls?

A. Yes. Because it comes from the actual licensing board that provides them with the prescribing privileges.

Q. Did you receive any information regarding Dr. Okeke's prescription credentials being compromised?

A. I started here in March, 2020, so I have not -- I can't attest to anything before that period of time.

But since March, 2020, I have not seen anything sent to us by the Pharmacy Board involving Dr. Matthew Okeke's prescription being compromised.

MS. BRADLEY: I have no further question for this witness at this time.

HEARING OFFICER HEALSTEAD: Thank you.

Mr. Agwara, cross?

CROSS-EXAMINATION

BY MR. AGWARA:

Q. Mr. Diaz, have you ever worked for the Pharmacy Board?

A. No, sir.

Q. How do you know how the Pharmacy Board handles complaints regarding compromised prescription pads?

A. I do work joint investigations with the Pharmacy Board, it's fairly common. And the reason that I know the process is because in interactions with other Pharmacy Board investigators, this is not an uncommon thing that happens, so we either notify each other, and then we get the official notification from the Pharmacy Board that a prescribing registration has been compromised.

Q. Is it fair to say that your knowledge on how the Pharmacy Board handles complaints is based on what you were told by some other pharmacy investigator?

A. Yes. My interactions with my counterparts at the Pharmacy Board, we do share information.

Q. Okay. Do you know what Sana is?

A. Other than my review of the records, it's a behavioral health center or hospital.

Q. Do you know who their medical director was at the time?

A. I believe it was Dr. Matthew Okeke.

Q. How do you know that?

A. Review of the records and also, I believe,

in reviewing some of the responses that he provided.

Q. Okay. In your investigation, did you try to determine how his name appeared on the handwritten prescription pads, or your investigation was limited to just collecting medical records?

A. Well, the previous investigator obtained as much information including records and responses from Dr. Okeke regarding this case.

Q. That's what I'm saying. I mean, was she limited to just collecting records, or is it part of your team's responsibility to also go beyond just obtaining the records, but questioning or learning how the provider's name get on a prescription pad or is completely handwritten in handwriting that is not his?

A. Are you asking me if we analyze the doctor's signature on the prescription pads?

Q. No. I'm asking if you guys try to ascertain how a doctor's name got on a prescription pad that was handwritten? If that's not part of your investigation, that's okay.

A. I can't attest to what the previous investigator did other than what I see in a case file. But I can tell you, I did not personally do that.

Q. Okay. There were no documents in the file that explain how Dr. Okeke's name got on the prescription pad?

A. Not that I saw.

Q. Some of those prescription pads had -- prescriptions had initials next to either the line where Dr. Okeke's appeared.

Did you see anything in the file that explained who may have -- whose initials those may have been?

A. You would have to direct me to an exhibit to look at. I just can't --

Q. Hold on. Let me see. What was the one for --

MR. AGWARA: Ms. Bradley, do you know which exhibit it is?

MS. BRADLEY: Which exhibit, you mean the ones with the handwritten notes, the handwritten names?

MR. AGWARA: Yes.

MS. BRADLEY: I think it's the prescriptions -- let me check.

So 12 is the first prescription record. But I believe is the one that was signed by Dr. Okeke. 17 is another prescription record, and this

one is handwritten with initials. Exhibit 20 is very similar to Exhibit 17, although this one has a name there that's crossed out and then "Matthew Okeke" is written in. And then the last one is 25, and this one is also handwritten, and says "Bruce," instead of initials. Well, maybe there's initials under that, but it says "JJ." I don't know.

MR. AGWARA: Okay. Yeah.

BY MR. AGWARA:

Q. Mr. Diaz, let's look at Exhibit 20.

A. I'm there.

Q. Let's take for example this one. Did you find any documents or explanation in the investigation file explaining whose initials are contained on this prescription?

A. No. I can't make out the initials either.

Q. Okay. Was there any explanation as to -- or that you could find regarding why the first name was crossed out? It looks like "Lopez," somebody.

A. I don't have an explantation for that.

Q. Okay. There is a name below that that says "Mary," and did you find anything in the file explaining who Mary is?

A. No.

Q. Is it fair to say that -- who was the

investigator on this, Ms. Friedman?

A. Yes, sir.

Q. Is it fair to say that Ms. Friedman did not obtain any evidence regarding who put Dr. Okeke's name on there and why and whose initials those are?

A. I didn't see any information regarding what you just asked me.

Q. Well, is it fair to say that there was no information and that she didn't put anything in there?

A. I can't locate any in the case file.

Q. Now, if you were doing this investigation, would you have asked questions regarding those initials and why the provider's name would be crossed out?

A. I do know that certain prescriptions can be phoned in, and my understanding is -- again, in working with the Pharmacy Board investigators -- they usually write down the name of the person that phoned it in on behalf of the provider. That's my understanding of why sometimes an actual medical doctor who has prescribing privileges doesn't actually sign the prescription pad, I believe, if it's phoned in.

Q. Okay. And from your experience, is there anything wrong with phoning it in back in 2019?

A. No.

Q. Okay. But my initial question was if you are investigating this case, would you have made attempts to find out why the name was crossed out or whose appeared on the prescription?

A. I, myself, would have probably done that, yes.

Q. Thank you.

MR. AGWARA: I don't think I have any more questions.

HEARING OFFICER HEALSTEAD: Ms. Bradley, redirect?

MS. BRADLEY: I don't have any redirect.

HEARING OFFICER HEALSTEAD: Okay. And who is your next witness?

MS. BRADLEY: My next witness will be Darla Zarley. I would reserve Mr. Diaz just in case I do need him for rebuttal.

HEARING OFFICER HEALSTEAD: Thank you.

Mr. Diaz, you are reserved for rebuttal, so you can leave the Zoom subject to being recalled.

THE WITNESS: Okay. Thank you.

HEARING OFFICER HEALSTEAD: Thank you.

MS. BRADLEY: Let me text Ms. Zarley to join us.

HEARING OFFICER HEALSTEAD: Just procedure-wise, is Dr. Chen scheduled again at 1:30?

MS. BRADLEY: Yes.

HEARING OFFICER HEALSTEAD: And how long do you anticipate Ms. Zarley will take? I know you can't account for cross.

MS. BRADLEY: Yeah. I don't think very long. I only have one page of questions, so I don't think very long.

HEARING OFFICER HEALSTEAD: Okay. Thank you.

MS. BRADLEY: She's logging in now.

(The witness joined the hearing.)

(The oath was administered.)

DIRECT EXAMINATION

BY MS. BRADLEY:

Q. Ms. Zarley, please state your name and spell your last name for the record.

A. Sure. Darla Zarley, Z-A-R-L-E-Y.

Q. Who is your employer?

A. Nevada State Board of Pharmacy.

Q. What is your job title?

A. Prescription Monitoring Program

administrator.

Q. How long have you had that position?

A. Six years.

Q. Do you have any other Pharmacy Board experience?

A. Yes. I was appointed to serve on the Nevada State Board of Pharmacy as a board member from the Governor's office from 2015 to 2018.

Q. Are you a licensed pharmacist?

A. Yes, I am, for 27 years.

Q. Have you reviewed Exhibits 10, 11, 15, 16, 18, 19, 23, 24, 28, and 29 before?

A. Yes, I have.

Q. What are they?

A. They are different reports, but some of them are reports that show the query history of a patient. Do you want me to list out which ones are which?

Q. Sure. Go ahead, if you can.

A. Okay. Exhibit 10 is a patient query history report.

Exhibit 11 is a patient's PMP report, that's their controlled substance history report.

Exhibit 15 is a patient query history report.

Exhibit 16 is the patient's PMP controlled substance history report.

Exhibit 18 is a patient's query history report.

Exhibit 19 is a patient's PMP controlled substance report.

Exhibit 23 is a patient's query history report, so that shows everybody who has queried them.

Exhibit 24 is a patient's controlled substance -- or PMP controlled substance history report.

Exhibit 28 is the patient's query history report.

And Exhibit 29 is the patient's controlled substance or the PMP report that the practitioner would run.

Q. Okay. Based on your review of the exhibits and information in this case, would you agree that -- I believe it's Exhibit 10, 15, 18, 23, and 28, you just said are the query history for patients A, B, C, D, and E?

A. Correct.

Q. Do you see that Dr. Okeke queried those patients' history in the time period at issue in

this case?

A. He did not.

Q. What is the purpose of the patient utilization reports?

A. The patient utilization report is a tool for the doctor to review the patient's controlled substance history for them to make a clinical decision on whether they want to prescribe a controlled substance to them, to deem if a controlled substance is medically necessary.

Q. And what is the requirements in the Nevada law for a physician to obtain that report?

A. They must query the patient's report prior to prescribing a controlled substance and then every 90 days thereafter if they are going to continue to prescribe that controlled substance to them.

Q. When did that requirement become effective?

A. January 1, 2018.

Q. Just for informational purposes, was it available prior to January 1, 2018?

A. It was.

Q. Okay.

HEARING OFFICER HEALSTEAD: I've written it down before, but I want to make sure, your

testimony was it became required on January 1, 2019?

THE WITNESS: 2018.

HEARING OFFICER HEALSTEAD: 2018. Thank you.

BY MS. BRADLEY:

Q. Did Dr. Okeke meet that requirement for patients A, B, C, D, and E according to the exhibits you reviewed?

A. No, he did not.

Q. As a staff member at the Board of Pharmacy, do you also have -- and as an administrator of the PMP, do you also have access to the self-query history for physicians?

A. I do.

Q. Do you know if Dr. Okeke self-queried himself in 2018 and 2019?

A. I ran that report. Can I grab it?

Q. Yes. Thank you.

(Witness retrieving document.)

THE WITNESS: What time frame are you referring to?

BY MS. BRADLEY:

Q. This case deals with care to one patient from January 2018 to July 2019, and then other patients from November 2018 to December 8, 2019. I

think we could say the whole year of 2018 and the whole year of 2019, did he self-query?

A. He did not query in 2018. But in 2019, he queried on June 8, 2019, and then he didn't query again until April 6th of 2020.

Q. Okay.

A. So once in 2019, and he did not query at all in 2018.

Q. Okay. As a part of your duties as the Prescription Monitoring Program administrator, do you became aware when a licensee's prescribing credentials have been compromised?

A. If they notify us.

Q. If the Pharmacy Board is notified that prescribing credentials have been compromised, you become aware of that as part of your duties?

A. Yes, if they let us know.

Q. Do you recall ever receiving such a notification regarding Dr. Okeke?

A. No, I do not.

Q. Not during 2018, 2019?

A. No.

Q. Okay. Thank you.

MS. BRADLEY: I have no further questions for this witness at this time.

HEARING OFFICER HEALSTEAD: Mr. Agwara?

CROSS-EXAMINATION

BY MR. AGWARA:

Q. Ms. Zarley, is it okay for a physician to query the PMP on a patient that is not his?

A. No. There has to be a patient/doctor relationship. If he is prescribing to that patient, he is required to query them.

Q. Okay. So do you know how many of these patients appear to be Dr. Okeke's patients?

A. I don't know that.

Q. When you stated that --

A. If he prescribed to them a controlled substance, he was required to query them under Nevada law.

Q. So you're now conditioning your previous statement about him on whether or not they were his patients?

A. Well, if he was prescribing a controlled substance to the patient, wouldn't they be his patients?

Q. Let me ask you this: Do you have any evidence that the five patients were his patients?

A. Do I have any evidence that they were his patients?

Q. Yes.
A. What I have evidence of is that he prescribed a controlled substance to these people.
Q. That's not what I asked you.
Do you have any evidence that they were his patients?
A. No, I do not.
Q. What evidence do you have that he actually prescribed to these patients?
A. The PMP report that was pulled.
Q. The PMP showed that he prescribed to them?
A. Yes.
Q. And did you make any effort to determine if actually it was him that prescribed or merely written down as the prescribing physician?
A. I think we pulled prescriptions for some of these. I don't know if we have prescription hard copies for all of them.
Q. Do you have Exhibit 20?
A. I do.
Q. Okay. This is a handwritten prescription; right?
A. It is.
Q. Okay. Do you see Dr. Okeke's signature anywhere on that prescription?

A. I see his name on it.
Q. Okay. And it looks like it was handwritten?
A. Yes. It looks like this might have been -- I can't tell. It looks like it might have been a phoned-in prescription.
Q. Okay. And do you have an explanation as to how the name that's crossed out, Lopez, something, Mark, how that name got crossed out or by whom?
A. I do not. This record would have come from the pharmacy.
Q. Okay. And what drugs are here, do you know if they are Schedule 4 or 3?
A. Suboxone is a Schedule 3.
Q. Let me ask it this way: Do you see any Schedule 2 drugs on the prescription?
A. I do not.
Q. So even if this had been called in back in 2019, would that have been proper for a Schedule 3 or 4?
A. Yes.
Q. Okay. Do you know what Sana is?
A. I'm sorry, what what is?
Q. S-A-N-A, those are initials for the --

from where records came from. Let's see.

Let me ask it this way: If for some reason the patient is seen at a hospital without the presence or in the absence of the patient's psychiatrist or provider and they need to give medications to that patient, who do they put down as the prescribing physician on the prescription?

A. Okay. I just want to make sure I understand your understand question.

A patient went to the hospital --

Q. Um-hum.

A. -- and they are leaving the hospital; correct?

Q. Assuming so, yes.

A. Okay. And then there is a prescription called to the pharmacy for this patient, is that what you're talking about?

Q. Let's assume that too, yes.

A. Okay. So the practitioner who saw the patient at the hospital would be the one who would call that prescription in.

Q. Okay. And, normally, their name would appear on this or the pharmacist may actually put another name that he has on record for the patient, which one?

A. So the pharmacist would write down who -- which practitioner was prescribing the medication.

In this instance, I don't know who took the order, which pharmacist took the order, but they wrote down on this one "Matthew Okeke."

Q. Okay. So but you see there's another name before that was crossed out; correct?

A. I do see that.

Q. So in your experience, the pharmacist should have put down whoever called in the prescription?

A. It looks like -- if you look below at this prescription, there's a name, it looks like "Mary."

Q. Yes.

A. Under Nevada law, if someone is calling in a prescription on behalf of the practitioner, the law says we have to put down that person's name. That's what this looks like to me. Again, I wasn't involved in this, I didn't take the prescription. But it looks like there's an individual named Mary who called in this prescription for Dr. Okeke with Dr. Okeke's DEA number.

Again, I can only tell you what I see on this paper because I didn't take this prescription personally.

Q. Okay. Is it possible that the pharmacist at the hospital may have put down a different name as the attending physician?

A. That the pharmacist?

Q. Yes.

A. It looks like this prescription was called into Well Care Discount Pharmacy, according to the top of the prescription, so somebody from the hospital would have called the pharmacy there and provided the information. Then the pharmacist would have transcribed that prescription.

Q. Okay. I'm trying to understand. But it is your testimony that if Dr. Okeke had called in schedule 3 or 4 at the time, it wouldn't be a problem?

A. He can call in a prescription at that time.

Q. All right. Thank you.

MR. AGWARA: I don't think I have any further questions.

HEARING OFFICER HEALSTEAD: Can I ask a quick follow-up question?

MS. BRADLEY: Sure.

HEARING OFFICER HALSTEAD: Ms. Zarley, I want to make sure I took my notes right, you said it

looked like that the prescription was called with Dr. Okeke's prescribing number.

THE WITNESS: His DEA number.

HEARING OFFICER HEALSTEAD: And did you confirm that that's actually Dr. Okeke's DEA number?

THE WITNESS: I can pull that up, but I believe so because I have been looking at reports. Do you want me to pull that up quickly?

HEARING OFFICER HEALSTEAD: Yeah. I want to confirm whether that's actually his number or not, because that's what you testified to.

THE WITNESS: Yeah. Let me double check.

(Witness reviewing document.)

THE WITNESS: This DEA number does not match the ex-DEA number we have on file for Dr. Okeke. What I could also do is run it through the system so see who it belongs to.

HEARING OFFICER HEALSTEAD: While you're doing that, who would have provided the DEA number? Would that be from the caller or would the pharmacist have just put one in?

THE WITNESS: It would have to be whoever called it in. If this individual was Mary who called it in, which is written on the prescription, it's their responsibility to provide that.

I'm going to run a report real fast and see if I can identify that DEA number because sometimes practitioners do have more than one DEA number.

All my system is saying right now is "DEA number is valid, but we cannot find it on the dominus." So I would have to do a little more digging to figure out whose DEA number that is written on here.

What I am reading on this prescription, the DEA number on here is X0158 -- either a 4 or 9, I ran it both ways -- 095.

HEARING OFFICER HEALSTEAD: Can you look at Mark Lopez and see if that's the DEA number for that person?

THE WITNESS: Yes.

MR. AGWARA: It looks like it could even be a 6, people and their handwriting.

THE WITNESS: I can't tell what the number is.

So, no, that's not his DEA number either. But I didn't run it as a six. Are you thinking 1586095?

MR. AGWARA: Let's try that and see.

THE WITNESS: Okay. It's not Lopez,

though.

MS. BRADLEY: Is it possible it's X04173845? Because that's what was written in -- typed on the typed prescription in Exhibit 12.

MR. AGWARA: Well, can we just -- if it's okay, can we have just one on all the five --

MS. BRADLEY: I'm sorry. I just was trying to see one that was typed more easily to see, but it's a totally different number, so never mind.

THE WITNESS: Yeah, this DEA number on there, I don't know if it was transcribed incorrectly. But I can tell you as a pharmacist, when you get a prescription called into you, you write down what they give to you.

I'm not sure what this DEA number is.

HEARING OFFICER HEALSTEAD: What is Dr. Okeke's DEA number?

THE WITNESS: He has couple. Let me give those to you. We have one that is expired, you want that one as well?

HEARING OFFICER HEALSTEAD: Yes.

THE WITNESS: The expired one is BO7677593.

HEARING OFFICER HALSTEAD: When did that one expire?

THE WITNESS: I'd have to run it. Let me give you the other one and then I'll run the other one.

HEARING OFFICER HALSTEAD: Okay.

THE WITNESS: The one that shows active is FO4173845.

HEARING OFFICER HEALSTEAD: Okay. That's okay, I don't need to know when they expire.

THE WITNESS: But there's another one which is no longer really used. He has an ex-DEA number, which it's not required under federal law anymore, it's the exact same DEA number as the one that is active, but it starts with an X, so it's XO4173845.

Again, they're not required anymore, but he did have one or does have one. I don't know if that one is still -- that one's not required anymore.

HEARING OFFICER HEALSTEAD: Okay. And I don't think you can answer this, but if someone else called this in -- well, actually, I do think you can answer because of the reports.

I'm going to ask you this as directly as I can. If someone else called this in, he wouldn't know -- same and except for he is supposed to run

his own query every six months and then he would have spotted it?

THE WITNESS: Correct. That's why that is put into law. Every six months, that practitioner is supposed to query through my RX report, which -- they need to look at their patients that they've seen, compare it to what they see in the PMP report, and see if there's any discrepancies to identify if somebody shows up on his report that is not his patient.

HEARING OFFICER HEALSTEAD: And this showed up on his report?

THE WITNESS: I have to go back to this one. There's a lot of pages here.

Patient D. Okay. There's one on there for 11/27/2019. Is that the date of that prescription?

HEARING OFFICER HEALSTEAD: Yes.

THE WITNESS: Yes, that is showing up on his report.

HEARING OFFICER HEALSTEAD: Mr. Agwara, before Ms. Bradley does her redirect, does that raise any questions for you that you would like to follow up on?

MR. AGWARA: Was that for me?

HEARING OFFICER HEALSTEAD: Yes. I want to make sure -- I want to see if you have any questions based upon my questions before I turn it back over to Ms. Bradley for redirect?

MR. AGWARA: Yeah.

FOLLOW-UP QUESTIONS

BY MR. AGWARA:

Q. Did you -- the other four or five prescriptions, could you identify for sure if it was Dr. Okeke's DEA number on those?

A. I did not look at those DEA numbers. We can do that right now.

Q. Please, let's do.

A. Okay. Patient C --

MR. AGWARA: Ms. Bradley, if you could help?

MS. BRADLEY: The prescriptions, I think, are -- Exhibit 17 is Patient C.

THE WITNESS: Let's go to that one.

MS. BRADLEY: B is the one that is actually, like, printed on a prescription pad, it's typed.

MR. AGWARA: Yeah, that's fine.

MS. BRADLEY: So 17.

THE WITNESS: So 17 is his DEA number.

BY MR. AGWARA:

Q. It has "Mary" on it; correct?

A. It has Mary. It looks like somebody -- I don't know -- I don't know if that Mary is working in his office, that is what it looks like to me, Mary from Dr. Okeke's office is calling in this prescription to Well Care Pharmacy.

Q. Well, do you see where the address, up there, says "Sana"?

A. Oh, okay.

Q. Yeah. So we can't really tell for sure, can we, whether Mary's working?

A. It might be the nurse from the facility.

Q. Yeah.

A. The next prescription you want me to look at?

MR. AGWARA: Ms. Bradley, would that be 20?

MS. BRADLEY: Yeah. We just looked at 20. The next one would be 25, and that's also, like, a the handwritten-looking one.

THE WITNESS: Let me take a look.

MS. BRADLEY: I think it's the same number as in 17, it looks like.

THE WITNESS: Yes. That one is his as

well.
BY MR. AGWARA:
Q. And it doesn't have the "Mary" there, does it?
A. I don't see Mary on there.
Q. It has a "Bruce," same line?
A. Yeah. It looks like that's who called it in this time.
Q. Okay. Then --
MR. AGWARA: Ms. Bradley, do you have the exhibit number for the next one?
MS. BRADLEY: Yes. 25. We're on 25. I think that's it.
MR. AGWARA: Only three?
MS. BRADLEY: Yeah. Three that are handwritten and one that's not.
BY MR. AGWARA:
Q. Ms. Zarley, do you show these are the two on the query list?
A. Let me take a look. Let's go to -- 25 is Patient E. Let me look at the PMP report, which is 29.
Yes -- well, actually, the dates match. There is a Klonopin, which is clonazepam, written on 11/15/2019. That matches for this patient for Dr.

Okeke. Well Care Pharmacy is the dispensing pharmacy for the a quantity of 60 tablets for VID, that means twice a day.

Yes, this one matches as well.

What was the other number?

Q. 20.

A. I think we checked 20. It was the one before that; correct?

Q. Yeah, I think you're right. And it matched? Or this is the one with the wrong DEA number?

A. That one matched but -- there was one before that.

Q. Seventeen.

A. Okay. On 17, it's a Klonopin prescription, one milligram, VID number 14, written on 11/27/19. The PMP report shows a prescription filled on 11/27/19, written on 11/27/19, for Klonopin, which the generic is clonazepam, for a quantity of 14. That matches. Dr. Okeke -- so that does match for 7-day supply, and it is Well Care Pharmacy. That one matches.

Q. So we have no way of knowing who called it in or who put his name on there or who this Mary is?

A. Yeah. The name is Mary on this one and

one of the others, and one is Bruce. But I don't know who those individuals are.

Q. Actually, this exhibit would be the actual copy that the pharmacy received; is that correct?

A. That they would have written -- yeah, that's what the pharmacy has on file, this is what they would have transcribed down.

So when this person called it in, the pharmacist would have written it out, and this is what their record looks like.

Q. So this here was handwritten by the pharmacy not someone from the doctor's office?

A. It looks like it's a phoned-in prescription, so, yes, it would have been written by the pharmacist.

Q. Okay. Now, where you aware that Dr. Okeke was not in the country as of that date?

A. I learned that with this case. Otherwise, no.

Q. Okay. That would have been Exhibit 17, 20, and 25, that he was not in the country on those dates that those prescriptions were written.

You are aware of that now; is that correct?

A. Yes.

Q. Okay. And was your testimony previously that even if he had called them in, that would have been okay because they were Schedules 3 and 4?

A. A practitioner can have someone, a delegate, call it in on their behalf. Yes, that is true.

Q. Okay.

A. Then before they were electronic, yes, of course.

MR. AGWARA: That's all the questions I have.

HEARING OFFICER HEALSTEAD: Ms. Bradley, redirect?

MS. BRADLEY: I don't believe I have any redirect for Ms. Zarley.

HEARING OFFICER HEALSTEAD: Okay. Thank you, Ms. Zarley. We appreciate your time again.

THE WITNESS: I'm free to go?

HEARING OFFICER HALSTEAD: That is up to Ms. Bradley. She may want you to remain subject to recall.

MS. BRADLEY: At this time, I don't think I'll need you. But if I do, it would be in a rebuttal case. I'll text you if that happens.

THE WITNESS: Okay. All right. Thank

you.

HEARING OFFICER HEALSTEAD: Ms. Bradley, next witness is Dr. Chen?

MS. BRADLEY: Yes.

HEARING OFFICER HALSTEAD: And she will be available 1:30.

MS. BRADLEY: Yes.

HEARING OFFICER HEALSTEAD: Okay. If everyone is good, we will break for lunch until 1:30.

MR. AGWARA: Sounds good.

HEARING OFFICER HEALSTEAD: And we will start promptly then. If for some reason there's going to be a delay, let's send some emails so that we know. Okay?

MS. BRADLEY: Thank you.

HEARING OFFICER HEALSTEAD: Thank you, everyone.

(Lunch recess at 12:19 p.m. to 1:32 p.m.)

HEARING OFFICER HEALSTEAD: Dr. Chen, please raise your hand to be sworn.

(The oath was administered.)

HEARING OFFICER HEALSTEAD: I forgot to say we're back on the record in case number

24-22461-2, In the Matter of Charges and Complaint Against Matthew Obim Okeke, M.D.

We took a break for lunch. It is now 1:33, we're officially back on the record. Dr. Chen has been sworn and been called by the IC.

Ms. Bradley, your witness.

MS. BRADLEY: Thank you.

DIRECT EXAMINATION

BY MS. BRADLEY:

Q. Would you state your name and spell your last name for the record?

A. Jayleen Chen, C-H-E-N.

Q. Are you licensed as a medical doctor in the State of Nevada?

A. Yes.

Q. For how long?

A. About -- since 2010.

Q. Are you licensed anywhere else?

A. No.

Q. Where did you go to medical school?

A. University of Nevada School of Medicine.

Q. What was your residency in?

A. Psychiatry.

Q. Did you complete a fellowship?

A. Yes.

Q. What was your fellowship in?
A. Child and adolescent psychiatry.
Q. Where was that done?
A. Here in Reno at the same school.
Q. Okay. Are you certified by the American Board of Medical Specialties?
A. Yes.
Q. What specialty?
A. Psychiatry and child and adolescence psychiatry.
Q. What kind of medicine do you practice?
A. Psychiatry. I see adults, children, and adolescents.
Q. Please turn to what has been premarked as the Board's Exhibit 32.
Do you recognize this document?
A. Yes, I do.
Q. What is it?
A. It's my curriculum vitae.
Q. Does this appear to be a true and correct of your curricula vitae as provided to the Board?
A. Yes.
Q. Does this document accurately summarize your experience and education?
A. Yes.

Q. And you prepared this document?
A. Yes.
MS. BRADLEY: Based on Dr. Chen's testimony, I would ask that Exhibit 32 be admitted into evidence.
MR. AGWARA: No objection.
HEARING OFFICER HEALSTEAD: All right. Exhibit 32 is admitted.
(The Board's Exhibit 32 was admitted.)
BY MS. BRADLEY:
Q. Have you served as a peer reviewer for the Board before?
A. Yes, I have.
Q. How many cases have you reviewed for the Board?
A. I believe it's seven.
Q. How long have you been reviewing cases for the Board?
A. I believe since 2016.
Q. Are you familiar with investigation number 22-213 -- excuse me. Wrong name.
It should be 19- -- I'm looking at the wrong binder -- 19-19115?
A. Yes.
Q. And I believe that's now what we're

calling legal case number 24-22461-2?

A. Yes.

Q. Would you turn to what's been premarked as the Board's Exhibits 30 and 31?

A. Yes.

Q. Have you seen these documents before?

A. Yes, I have.

Q. What are they?

A. Those are just kind of -- I believe these are the sources that I used to help me with this peer review.

Q. Do these appear to be true and correct copies of sources that you relied on when assessing Dr. Okeke's care provided to Patients A through E in this case?

A. Yes.

Q. And you provided these to the Board?

A. Yes.

MS. BRADLEY: Based on Dr. Chen's testimony, we would ask that Exhibits 30 and 31 be admitted into evidence.

HEARING OFFICER HEALSTEAD: Mr. Agwara?

MR. AGWARA: No objection.

HEARING OFFICER HALSTEAD: Those will be admitted.

(The Board's Exhibit 30 and 31 were admitted.)

BY MS. BRADLEY:

Q. Okay. Dr. Chen, did you review -- now, we have exhibits that have been marked and admitted, 1 through 29, but we omitted 5, 13, 22, and 27, so I'm not going to ask you about 5, 13, 22, or 27.

Have you reviewed the other exhibits in that 1 through 29 premarked number?

A. Yes.

Q. And that was done as a part of your review in this case?

A. Yes.

Q. Let's start with Patient A. Do you have an opinion regarding whether or not Dr. Okeke met the standard of care in his treatment of Patient A?

A. I felt that his care fell below the standard of care for Patient A.

Q. What made you say that his -- before we get there, where and how did you learn the standard of care for psychiatry?

A. Just through training, through school, and through just my practice.

Q. Okay. This is something that you're taught in your residency, your fellowship, medical

school, exams, and your practice?

A. Yes.

Q. Okay. What leads you to believe that Dr. Okeke's care of Patient A in this case was not done according to the standard of care?

A. From my notes and just looking back at it briefly, I know that there was a complaint, I think, that was made on the patient on behalf -- by their mother or family member, worried about some of the side effects of the medications.

And then just going on through the history and trying to review the notes, I felt that Dr. Okeke could have been more diligent in reviewing the Prescription Monitoring Program because there were lots of medications there that could have interacted with each other to cause some of side effects that the mom was worried about.

Q. Okay. Do you know if Dr. Okeke was prescribing benzodiazepines to the patient?

A. From the notes, yeah, it appears that he was, I believe. Yes.

Q. Was the patient also receiving opioids from another provider?

A. From checking the -- it appears that she was, if I can remember correctly. There was a

period of time where she was.

Q. Do you have -- what concerns do you have about a patient who is receiving benzodiazepines at the same time as opioids?

A. They could definitely have a synergistic affect and lead to respiratory depression and even death if misused on taken inappropriately.

Q. So are there instances where you might prescribe a benzodiazepine to a patient who is already receiving opioids from another provider?

A. I would say yes if it wasn't, like, a chronic condition. If they had just had surgery, there was a short course of opioids on board, they may have needed a short course of benzodiazepines if they had a lot of anxiety surrounding the surgery and recovery. Then if they we're, obviously, being monitored pretty closely as well.

Q. You said for a short time period you might do that. That would not be part of your long-term care?

A. No.

Q. Why not?

A. Just, again, because if in the event that they mistook their medications, it could be lethal or cause some serious side effects when taken

together.

Q. Do you take caution regarding patient care even if they may follow -- not follow your direction?

A. Yeah.

Q. What would you do in a situation where you have a short-term need to provide benzodiazepines to a patient who is also taking opioids?

A. I would only prescribe a limited amount of the medication so I could be more on top if they are requesting refills, and then kind bring it to their attention or try to figure out what's going on.

Q. It sounds like you would have a conversation with the patient?

A. Yes.

Q. And would there be documentation in your records regarding what you were doing?

A. Yes.

Q. If we turn to -- Patient A's medical records are in Exhibit 7. I think we will continue to talk about those. Please turn to Exhibit 7.

Do you if know Dr. Okeke checked the PMP report for Patient A?

A. I don't believe he did.

Q. Okay. And if we look at the Complaint --

I just want to say if you turn to NSBME 0175, I think it's a few pages into Exhibit 7.

A. Yes.

Q. Okay. You see that record.

What is the date on that one?

A. The visit date was 9/25/2013.

Q. Okay. I think the Complaint really in this case deals with care provided in 2018, so I'm going to go ahead and turn to the first record we have for 2018.

If you can turn to NSBME 0262, this is the first visit that Dr. Okeke had with Patient A. In 2018, excuse me.

A. Yes.

Q. Now, on January 1, 2018 -- are you familiar with the requirement to query the PMP program?

A. Yes.

Q. And what's the rule for that?

A. You have to check the PMP upon initiation of a controlled substance and every few months thereafter, or every 90 days if you're still prescribing it.

Q. Okay. If we turn to page 0263 in this record for Patient A, do you see a list of current

medications?

A. Yes.

Q. What is your opinion regarding that list of current medications?

A. There's several medications on this list that are scheduled and there are different dosages for these medications. Some are for pain, some are stimulants, and is some are benzodiazepines.

Q. Would you expect that the patient would be taking all these medicines at the same time?

A. No.

Q. Would you classify, just based -- looking on this list, this record as clear, legible, accurate, or complete?

A. Just not accurate.

Q. Okay. If you were to take over the care of the patient, would you be able to determine what medications they were taking?

A. Not too clearly.

Q. Okay. And if we turn to page 0265 --

MR. AGWARA: Objection. Actually, withdrawn. Don't worry about it.

MS. BRADLEY: Okay.

BY MS. BRADLEY:

Q. If we go to 0265, do you see the section

where it says "Treatment Plan"?

A. Yes.

Q. And what does it say?

A. It says, "Continue present management." Then it goes through, medication management was discussed and how visit went, I guess, and some benefits and side effects.

Q. If you looked at treatment medications, does that give you any clarity regarding the medications that the patient may have been taking?

A. Yes, it does, as far as the psychiatric medications go.

Q. Okay. But there's other medications that you still wouldn't know the accuracy about?

A. True.

Q. Okay. If we turn to the next record, starting on page 0266, I believe that is the second visit for 2018 with Patient A?

A. Um-hum.

Q. Do you have those same concerns regarding medications in this record?

A. Yeah. There's just the differences in the current meds versus the treatment meds, so it's the same.

Q. Okay. Is it -- would a summary of the

records that you reviewed for 2018 and 2019, because this goes on for about 20 visits, do you have those same concerns regarding the current medication list for Patient A in the medical records for those visits?

A. Yeah.

MR. AGWARA: Counsel, I apologize. I'm not sure that I remember her saying what the concerns are and whether it was specific to those exhibits.

MS. BRADLEY: Okay.

MR. AGWARA: I have not heard her say any concern about the exhibits yet.

MS. BRADLEY: Okay.

BY MS. BRADLEY:

Q. Dr. Chen, would you repeat your concerns regarding the current medications list for Patient A in the two exhibits we talked about, the January and the February?

A. Yes. The current medications do not match the treatment medications. I looked ahead a little bit, the one from March doesn't have a treatment medication section in the plan.

Q. Okay. And so as a provider, would you be able to understand the treatment plan and the

treatment medications for this patient based on records?

MR. AGWARA: Objection. She answered based on your question on current medications. Those are two sections: current and treatment medications.

They are completely separate. We worked through this yesterday.

MS. BRADLEY: We've been talking about current and treatment medications.

MR. AGWARA: Okay.

MS. BRADLEY: I'll continue to ask her about current treatment medication. But I already asked her. I think you just didn't hear.

HEARING OFFICER HEALSTEAD: I didn't get to rule on the objection, but my understanding of the question was she was asking just based on the records as they state.

Whether or not they both have -- whether they have both sections or not, would the records allow her to determine the current prescriptions and -- well, I stated that a little differently -- the current treatment with regard to prescriptions that the patient is taking.

Did I state that correctly, Ms. Bradley?

MS. BRADLEY: That's what I intended to be asking, and I believe that's what she was saying.

HEARING OFFICER HEALSTEAD: Right. And I think that is a proper question, and so any objection is overruled.

MR. AGWARA: I'm not -- my concern is counsel's use of terms "current" and then without asking about treatment medication, then she will ask the doctor's opinion. I think the doctor, if I remember correctly, it may not be today, understood the treatment medications to mean what the patient is currently on, and then the current medication in the total of what the patient as been on.

MS. BRADLEY: That was your testimony through your client. But Dr. Chen testified that she was unclear.

And I did ask her about treatment medications, and I'm glad to continue to ask her about that section as well.

HEARING OFFICER HEALSTEAD: But the question was: Based on records, regardless of how they are clarified between the two sections of medications, could she understand the treatment as far as medications that the patient is currently on?

And I still have not been able to get an

answer to that question.

Dr. Chen, can you please answer that question?

THE WITNESS: I feel with this case, it's harder to kind of gather. I would wonder if she is taking the Zoloft or not since that would probably be a better choice to handle long-term anxiety and mood issues. It's not necessarily clear to me.

I think, like I said when I skipped ahead to the next section, it wasn't a treatment in the medication section, so I imagine that's where it kind of got confusing of what's changed.

BY MS. BRADLEY:

Q. Okay. You said "skipped ahead," do you mean that you turned to the March 2018 appointment and you're looking at NSBME 0273?

A. Yes.

Q. Okay. On 0273, you see "Treatment Plan." What's missing?

A. The treatment medication is not in there.

Q. And so in this one --

MR. AGWARA: What date are we looking at?

MS. BRADLEY: March 2018 is what I said, NSBME 0273.

MR. AGWARA: I don't see Zoloft there or

anything. I don't know where the Doctor got that from. Maybe that's what she's saying.

MS. BRADLEY: She's saying there is no treatment medication list in 0273. That's what she's saying.

MR. AGWARA: Okay.

MS. BRADLEY: All she has to rely is the list in current medications, which is 0271.

MR. AGWARA: That's correct. Okay.

MS. BRADLEY: Yeah, it is correct.

BY MS. BRADLEY:

Q. Dr. Chen, do you routinely collaborate with other providers?

A. Not routinely.

Q. Okay. But you have seen records that are maintained by other providers?

A. I have.

Q. Would you say that, based on your knowledge and experience and the records you've seen and reviewed, that the records that Dr. Okeke maintains for Patient A meet the standard of care?

A. I think they fall below the standard of care because they are hard to decipher what's going on.

Q. Why is it important that medical records

are clear, legible, accurate, and complete?

A. Just to get a good idea of what is going on with the patient. Again, if there was a transition of care, to kind of pick up seamlessly and to know what issues there are to address.

Q. Okay. And how many patients do you think -- well, in your practice, how many patients do you see a day when you're back to your full-time schedule?

A. Probably 16.

Q. Okay. So 16 patients a day. Probably 20 days a month?

A. Yeah.

Q. Okay. And is it fair to say you can't remember the details of all of your patients?

A. It's hard to remember every detail, yeah.

Q. So do you review your medical records as well to help you provide good care?

A. Yes.

Q. I believe with regard to Patient A, do you have concerns regarding him copying and pasting progress notes from visit to visit?

A. I guess my main concern there was, yeah, it just didn't really paint a good picture of anything that has changed, it's pretty much the

same. Subjective information for most of the visits.

Q. Okay. The objective information is the same for most visits?

A. Subjective and objective.

Q. Subjective. I'm sorry.

What else is the same?

A. The objective section as well.

Q. Okay.

MR. AGWARA: Are we discussing a particular visit record?

MS. BRADLEY: If you want to object, please say "object" rather than just ask questions.

MR. AGWARA: Okay. I can state that I have an objection. If it's a general question, I will say so, because I wasn't sure it was an exhibit we're looking at.

MS. BRADLEY: I didn't ask her about a specific page when I asked that question. I asked her if she had a concern regarding copy and paste -- or -- I believe that is what I said. Something about a concern regarding copy and paste regarding Patient A's records.

I intended to then go to a specific record.

MR. AGWARA: Thank you.

MS. BRADLEY: Yeah.

BY MS. BRADLEY:

Q. I did have a question before we look at specifics for Patient A.

If you have a seen a patient you've seen for a long time, how often does the information change regarding their subjective and objective portions of the record?

A. I feel like things do change every time you meet with them. I try to update even minor changes, like new stressors or changes with work or how things are going with family and friends, and things like that. That's what I choose to update.

Q. Okay. If we look at, for example, I'm going to look at page NSBME 0266, and that record is dated February 23, 2018. And then NSBME 0270, dated March 23, 2018.

If you look at "Chief Complaint," do you see differences in those two in the verbiages?

A. No.

Q. Would you expect to see differences there?

A. Potentially, yeah.

Q. Let's move on to NSBME 0274, dated April 20, 2018.

Do you see differences between the February and March visits in that section?

A. No.

Q. Now we have three visits, this is saying --

MR. AGWARA: I sorry. Objection. I mean, the sections -- anyway. Let me make sure. What were the pages? What I see is different from what her responses are.

MS. BRADLEY: 0266, that's the first page. 0270, and she's looking under the Chief Complaint section, that's the part she's comparing. And 0274. She's saying that those are the same.

MR. AGWARA: Okay. The reason I'm saying that is I don't know if she already had the notes, but you're not allowing enough time for comparisons to made. Maybe she reads much faster than we do.

HEARING OFFICER HALSTEAD: Well, okay, so -- I'm trying to determine -- Ms. Bradley, can put on her case however she sees fit.

Dr. Chen reviewed those records prior, and these records were provided to you prior. She's already seen these, this shouldn't be the time when you're seeing them for the first time.

If it is a time you're seeing them for the

first time and you notice a difference, then that's subject to cross-examination.

I don't want to have continual interruptions of Ms. Bradley's case. If you have difficulty following along and you need identifications, that is one thing, but I don't want keep derailing the presentation of her case based on --

MR. AGWARA: I mean --

HEARING OFFICER HEALSTEAD: You're interrupting me.

MR. AGWARA: I was --

HEARING OFFICER HALSTEAD: Well, I'm telling you what I'm saying.

MR. AGWARA: I'm getting sick and tired because you been very biased in your rulings. I'm going to make a record. I'm getting sick and tired of this.

HEARING OFFICER HEALSTEAD: You can make your record when I'm done speaking, Mr. Agwara.

MR. AGWARA: Okay.

HEARING OFFICER HEALSTEAD: She is entitled to make her case how- --

MR. AGWARA: I didn't stop her from making her case.

HEARING OFFICER HALSTEAD: Are you going to keep interrupting me?

MR. AGWARA: You need to remain unbiased, ma'am.

HEARING OFFICER HEALSTEAD: I am being unbiased. I am maintaining the hearing and I'm keeping it moving along.

MR. AGWARA: Not the way you're doing it. You're not going to maintain it for much longer --

HEARING OFFICER HEALSTEAD: If you don't like the way I do it --

MR. AGWARA: It's biased.

HEARING OFFICER HALSTEAD: -- you can take issue with it if you are not happy with my ruling at the end.

MR. AGWARA: I can make objections.

HEARING OFFICER HEALSTEAD: And I'm --

MR. AGWARA: You didn't ask me for --

HEARING OFFICER HALSTEAD: -- overruling -- you didn't make an objection. You're just directing her how to do her case.

MR. AGWARA: No. I'm asking for page numbers.

HEARING OFFICER HEALSTEAD: All right. And as I was saying, if you need page numbers, that

is one thing.

MR. AGWARA: That's what she gave me. And now --

HEARING OFFICER HEALSTEAD: (Inaudible) to do her case.

MR. AGWARA: -- we're going back and forth.

HEARING OFFICER HALSTEAD: Your questions are subject to a cross-examination.

So with that, Ms. Bradley, please go ahead and continue.

MR. AGWARA: And if this continues, we're going to stop, because we don't think this is fair to my client. Okay? I don't think you're being fair to my client. Okay? As a lawyer, you should know that I can make objections. Ms. Bradley identified the --

HEARING OFFICER HEALSTEAD: You're not objecting. You're telling her how to do her case.

MR. AGWARA: You wouldn't let me make --

HEARING OFFICER HALSTEAD: You --

MR. AGWARA: I'm trying to make a record, ma'am.

HEARING OFFICER HEALSTEAD: Okay. If you take issue with what she's doing, it's her case to

make. If you want to make an objection, that's different.

MR. AGWARA: Can I speak now?

HEARING OFFICER HEALSTEAD: Yes, now you may.

MR. AGWARA: Okay. Did I stop her from making her case? I asked about the page numbers. She gave me the page numbers and she directed me to the chief complaint sections. That was it.

Why you felt the need to tell me once again -- this is about the fourth time you've said it -- that it is her case, she can present it any which way she likes. Okay?

I've been doing this for over 20 years. I know it's her case. She already answered my questions. Okay? So please remain unbiased. There is no reason for you to say what you said. It's something you've said several times.

HEARING OFFICER HEALSTEAD: Okay. Your record has been made.

Please continue, Ms. Bradley.

BY MS. BRADLEY:

Q. I believe what we did was we compared three visits, January, February, and a March visit. No. I'm sorry. February, March, and April, that's

what we compared. And you saw the same verbiage in the Chief Complaint section?

A. Yes.

Q. Okay. Do you see that same copy and paste with regard to mental status examination for each of those visits?

A. Yes.

Q. Would you expect to see those being the exact same each time?

A. The mental status exam is give or take. I mean, I would try to update that as well.

Q. Okay.

A. And ask them their subjective mood, like, tell me your mood or your feelings today.

Q. Okay. It's fair to say at least that part, you would expect might be the same, it sounds like?

A. That's fine.

Q. And I believe we talked about the current medications list. Let's turn to -- go to 0277, do you see treatment medications for this April visit listed there?

A. There are treatment medications here.

Q. Okay. Let's move forward. Do you see -- I think I asked this and now I can't remember if it

was answered.

Do you see the same -- the continuation of the chief complaints section being the same for the patient throughout the medical records we have for Patient A?

A. I think there have been some changes now, I guess, in June. You can see there was an update that the patient didn't have insurance. And then -- let's see -- in July, there are little bit more changes to the subjective section.

Q. So the copy and paste concern that you have isn't there for every visit?

A. Not every visit.

Q. All right. I think I'm -- just for the record, what were the benzodiazepines that Patient A was taking based on her medical records?

A. Well, she has been prescribed Klonopin at varying dosages, and the Xanax at different dosages as well.

Q. Okay. And those are just a couple of kinds of benzodiazepines; correct?

A. Yes.

Q. Okay. Earlier we talked about what you might do if you wanted to prescribe a benzodiazepine to patient at the same time they were taking an

opioid.

Would part of your decision-making rely on the PMP?

A. Yes.

Q. In what way?

A. I would be able to pull up how recently they were prescribed and how recently they had filled their opioid prescription, and that could kind of give me an idea of whether it is appropriate or not to prescribe a benzodiazepine depending on their symptoms.

Q. Okay. But it sounds like it's not favored, in your opinion, to prescribe a benzodiazepine if you know they are taking an opioid?

A. If they are chronically taking an opioid, yeah.

Q. And "chronically" means?

A. If it's something that, unfortunately, they have to take every day for longer periods of time, not just post op.

Q. Okay. So do you see in Exhibit 3, page 0010?

A. Yes.

Q. Do you see where --

MR. AGWARA: Counsel, can you hold on and let me get to it.

Okay. What page number?

MS. BRADLEY: 0010, I think it's the only page in there.

MR. AGWARA: Okay.

BY MS. BRADLEY:

Q. Do you see the statement that is after that 3 with the parens?

A. Yes.

Q. What does that say?

A. "He checked the PMP regularly."

Q. Do you believe that to be true with regard to Patient A?

A. No.

Q. Did you check Patient A's -- have you reviewed it at least, not check it, as part of this case, did you review Patient A's utilization -- patient utilization report?

A. If it was provided, then yes.

Q. I believe it's Exhibit 11.

A. Yes.

Q. Okay. And if we go back to Exhibit 7, I'll give you a specific page -- first of all, for the record, what are the dates -- do you see the

dates on NSBME 0380?

A. Yes.

Q. What is the date range for this report?

A. December 31, 2017, through December 31, 2019.

Q. If you look at the actual fill dates and written dates at the bottom of that page, what date do you see?

A. The end of December of 2019.

Q. Then we go to 0382, what does this record start with?

A. February 13, 2019.

Q. Okay. So it appears, maybe, the range wasn't available that was searched?

A. Yes.

Q. All right. But I want to look at those dates, those appointment dates in 2019 to make sure that what was filled is what matches the medical records. Let's turn to the March, 2019 -- if we look at NSBME 0382 in Exhibit 11, do you see a prescription in March of 2019 from Dr. Okeke for Patient A? It looks like there's actually two.

A. March 2019?

Q. Yeah. It's a little bit up from the bottom of that page, 0382.

Q. Yes. So it was methylphenidate and the clonazepam.

Q. Okay. And just for the record, what are those medications?

A. Methylphenidate is an ADHD mediation, it's a stimulant, and clonazepam is a benzodiazepine.

Q. Okay. And so then if we look at the treatment medications on page 0318, that's Exhibit 7, do you see that, 0318?

A. Yes.

MR. AGWARA: Hang on guys. I'm trying to do this as fast as possible. It's not easy.

Okay.

BY MS. BRADLEY:

Q. If you were to compare the treatment medications on 0318, do those match the PMP prescription shown for March 4, 2019, written and then filled on March 5th?

A. Yes.

Q. Okay. Let's look at the next one. April 4, 2019, do you see that? It's a little bit more up on the page.

A. Yes, I do.

Q. And do you see page 0322, Exhibit 7, it's a medical record?

A. I do.
Q. Okay. Does that match the treatment medications?
A. Yes, it does.
Q. Okay.
MS. BRADLEY: And I just realized I have a problem with my Exhibit 7. I'm going to request a quick recess. For some reason, I'm missing the pages that come after 0322 in my printed copy.
MR. AGWARA: I'm confused. You have pages that are not part of the record already?
MS. BRADLEY: No. I have an error in how mine was printed. I think I can access the electronic records, but it's going to take me a second. I've been relying on my printed copy.
MR. AGWARA: That's fine.
MS. BRADLEY: It looks like there's just a couple of visits that didn't print for me.
BY MS. BRADLEY:
Q. If we go to treatment medications, so if I go to 0326, which is in Exhibit 7, do you see a treatment medication list there?
A. No.
Q. Okay. But if we look at the PMP for that visit, it looks it's like the bottom of NSBME 03 --

I'm sorry -- 0381.

A. Right.

Q. There were medications prescribed?

A. Yes.

Q. Okay. And --

A. Adderall was prescribed and clonazepam was prescribed at a different dose.

Q. A different dose than before the April visit?

A. Yes.

Q. Okay. Do you see that addressed in the record for the May visit? It says -- do you see anything in that May 19th visit that explains the change in medications?

A. For the May 20th visit, it just mentioned that she thinks Adderall may be making her forgetful, and she has fallen a few times and broken her bones.

Q. Okay. Wait. I think there's May 2nd, and the prescription at the bottom of NSBME 0381 are May 2nd?

A. Sorry.

Q. And then on May 2nd's medical record, there's 0326, and there's no treatment medications?

A. That's right. Sorry. I was looking at

the wrong date.

Q. Okay. When did the medications change? Did they change on May 20th?

A. On the 2nd.

Q. Oh, they changed on the 2nd.

Is there anything in the record for May 2nd that explains why there would be a change in the medications?

A. She -- it just says that her purse was stolen and there was a police report. And that she did not -- or she was not able -- or wants to get her medications. And it doesn't really tell me why there was a change, no.

Q. Okay. If you were to change controlled substances that your patients are taking, would you document the reason for that change?

A. Yes.

Q. Okay. So it seems like here there was a visit, May 2nd and May 20th, and prescriptions that might have been too close together. It sounds like there's documentation for that, but not the change in medication?

A. Yes.

Q. If we look at the May 20th medication, it looks like -- I'm sorry. May 27th, it looks like it

was written on the 20th, filled on the 27th, on the bottom of NSBME 0381?

A. Yes.

Q. It looks like one of the medications is even different from May 2nd to May 27th from the May 20th visit?

A. Yes.

Q. Okay. And so if there's dextroamphetamine, May 2nd, and then that methylphenidate --

A. Right.

Q. -- are those the same kind of medicines?

A. They are both stimulants, yes.

Q. Okay. And if you were to change the kind of stimulant, would you also document that in your record?

A. Yes.

Q. Okay. Go to the May 20th -- because it looks like it's the May 2nd one that suddenly has that new one.

Then May 20th, do you see anything -- and May 20th starts on 0327, NSBME?

A. Right. Well, there was mention that the Adderall was making her forgetful.

Q. Okay. But we don't know why she went to

Adderall in the first place?

A. Right.

Q. But then later on it says, "Patient wants to continue current medications."

That would mean continue the Adderall?

A. The current meds, is what I would think.

Q. Okay. And then we go -- I think there are two more visits that we talked about in the complaint. The June, 2019, medical record, if you turn to that.

MR. AGWARA: What exhibit?

MS. BRADLEY: We're still in Exhibit 7, that's where all the medical records are, and it's 0331, that's the June 26, 2019, medical record.

MR. AGWARA: 0331?

MS. BRADLEY: Yeah.

MR. AGWARA: That's not Exhibit 7. It is?

MS. BRADLEY: It is for me.

MR. AGWARA: I got it.

BY MS. BRADLEY:

Q. Then, Dr. Chen, if we go to the visit that matches this -- I'm sorry -- the PMP entry that matches with this, it looks like it's little bit on top of the one you're just looking at?

A. Right.

Q. Okay. Did the medication change again from May?
A. Yes, they did.
Q. Even though -- is that Adderall, the dextro- --
A. Yes, it is. The dextroamphetamine is Adderall.
Q. Okay. So she continued with that in June even though in May she said she thought it was making her forgetful?
A. Yes.
Q. If you look at the treatment medications on page 0334, which is the continued record for the June visit, do the treatment medications there match the treatment medications that show in the PMP?
A. Yes. The Klonopin is at a higher dose again.
Q. It's at a higher dose than it was in --
A. May.
Q. Is there anything in this record that explains why it would be at a higher dose?
A. No.
Q. And Klonopin is a benzodiazepine?
A. Yes.
Q. So if you were to increase a

benzodiazepine, would you document the reason?

A. Yes.

Q. If we go to 0331 and we look at the chief complaint, is there anything there that would support an increase in a benzodiazepine?

A. No.

Q. What would you expect to see as a rationale to increase a medicine like that?

A. I guess having more anxiety, maybe some panic attacks, or there was a stressor that is causing something different in her life that's leading to more anxiety symptoms or worry.

Q. And if we look at this chief complaint section, does this look to be the same as the ones we were looking at for February, March, and April of 2018?

A. Yes.

Q. This might be another example of copying and pasting?

A. Yes.

Q. All right. Let's look at PMP, still on 0381, Exhibit 11, the July entries for the prescriptions that Dr. Okeke provided to Patient A, it looks like they were written July 22, 2019, and filled on July 25, 2019.

Do you see those?

A. Yes, I do.

Q. Okay. Let's go to the medical record. Are those the same as the June prescriptions?

A. Yes.

Q. Okay. And the July visit that this correlates to is in Exhibit 7 and starts on 0335?

A. 7yes.

Q. And if we go to 0338, do you see the treatment medications section there?

A. Yes.

Q. Are those all controlled substances?

A. The Zoloft is not.

Q. Okay. But the other two are?

A. Yes.

Q. Do those match what the PMP shows that the patient had filled in July?

A. Yes.

Q. Okay. I think we're ready to move on to Patient B.

Oh, it does look like -- and we talked about it, I think, the two prescriptions in May. Did you receive -- I believe it's in Exhibit 9. Exhibit 9 are records from the Las Vegas Metropolitan Police Department.

Did you receive those as part of your review?

A. Yes.

Q. Do those provide some explanation, maybe, why there would have been two prescriptions in May?

A. Yes.

Q. Do you still have any concerns about that? I think specifically if we go to NSBME 0371, that's where there's a police report regarding a purse being stolen in May, 2019.

Does that provide sufficient explanation, do you think, for the two prescriptions in May, the May 2nd and the May 20?

A. Yeah.

Q. Okay. Is that something you have your patients do if they lose medications?

A. Yeah. I tell them to make a police report.

Q. Okay. All right. Let's move on to Patient B. For patient B, we need to turn to Exhibit 12, it's just couple of pages, but the first page is NSBME 0384.

Do you see that one, Dr. Chen?

A. Yes.

Q. What is Suboxone?

A. It's a medication to help those who have an opioid dependence to get off of the medication, essentially.

Q. Okay. And it's a controlled substance?

A. Yes.

Q. If we turn to Exhibit 14, it's medical records for Patient B.

What is the date of that prescription in Exhibit 12?

A. November 8, 2019.

Q. Okay. If we look at Patient B's medical records -- when you provide a prescription like that, do you have to see the patient on that day?

A. Yes.

Q. Okay. So you would expect to see an accompanying medical record for the date of November 8, 2019?

A. Yes.

Q. I'm looking at Patient B's medical records, Exhibit 14, and I see NSBME 0425.

Do you see that one?

A. Yes.

Q. What is the date of that record?

A. October 10, 2019.

Q. Then do you see a record just prior to

that one that's NSBME 0421?

A. Yes.

Q. What is the date for that record?

A. November 15, 2019.

Q. And do you see Dr. Okeke's name on this record as the attending physician?

A. It is Deborah Perkins.

Q. Okay. So in your review of the medical records for Patient B, do you remember seeing a medical record for Dr. Okeke for Patient B dated November 8, 2019?

A. No, I don't believe so.

Q. And does failing to provide a medical record for a date that he provided a prescription to the patient fall below the standard of care?

A. Yes.

Q. Are you -- did you also review the PMP query history for Patient B? And for the record, that's Exhibit 15.

A. Yes.

Q. Do you see a query for Dr. Okeke on that list? It's NSBME 0513.

A. I do.

Q. I know the date's kind of cut off there, but what does it say from what you can read?

A. February 28th, that's all I can read, really.

Q. Okay. But date of the prescription was November 8, 2019?

A. Yes.

Q. So it was either seven months before or seven months after that this query was done. Or not -- seven months before or three months after?

A. Right.

Q. And would that meet the requirement of Nevada law to query the PMP?

A. No.

Q. Let's move on to Patient C. Patient C's prescription is Exhibit 17.

Did you see this prescription before?

A. Yes.

Q. This one is an interesting-looking one. I don't see an actual signature from Dr. Okeke?

A. Right.

Q. Okay. What kind of medication is -- it looks like Klonopin, can you read the other one?

A. Robaxin is a muscle relaxer, and fluphenazine is an anti-psychotic.

Q. Okay. And I see a note that says "also faxed."

Would it be your belief this might have been a prescription that was faxed over or somehow provided in a different manner for this patient?

A. Yes.

Q. Okay. Are you aware whether Dr. Okeke was in the country on November 27, 2019?

A. I don't believe he was.

Q. Is someone allowed to prescribe -- so which ones on this list for Exhibit 17, 0517, are the controlled substances?

A. Just the Klonopin.

Q. Okay. And would the standard of care allow a prescriber to prescribe Klonopin without seeing the patient?

A. No.

Q. Is a physician allowed to delegate to someone else to send over a prescription in their name?

A. No.

Q. For a controlled substance?

A. No.

Q. Okay. But for other medicines, can they?

A. Yes.

Q. So if you do a, let's say, a faxed prescription for a patient, how do you do that, you,

personally, when you've treated a patient?

A. Well, I would write the prescription, of course, after having an appointment or whatnot, and then, I guess, whoever's in the office could help fax it to the pharmacy.

Q. But it would have your signature on it?

A. Yes.

Q. And could that be called into the pharmacy, a prescription for Klonopin?

A. They want a hard copy of controlled substances.

Q. Okay. And that was true in 2019?

A. Yes.

Q. Do you think this prescription falls below the standard of care?

A. Yes.

Q. Then if we turn to Exhibit 18. This is the patient history -- query history for Patient C.

Do you see a query that was done by Dr. Okeke on this page?

A. Yes.

Q. Okay. And, again, I know the date's kind of cut off. I think you can see it better.

What is the date of that query?

A. It's 2/18/20-something. I can't see the

bottom.

Q. But the prescription was written in November of 2019?

A. Yes.

Q. This query had to have been, if it was 2020, which would be the next time it could have been based on that second 2 there in the a year, it would have been almost exactly three months after the prescription was written?

A. Yes.

Q. Would that comply with the requirement to query the PMP for Patient C prior to prescribing?

A. No.

Q. Let's turn to Patient D. That prescription is in Exhibit 20, and that's page 0524.

What's your opinion regarding this prescription, just how it looks?

A. It was written by somebody else.

Q. And which medication on this list is a controlled substance?

A. Suboxone.

Q. Okay. I'm thinking it's similar to what we just talked about with Patient C. Is this a -- we've got this November 27, 2019, date.

Do you know if Dr. Okeke was in the

country on that date?

A. He was not.

Q. Would it be the standard of care to issue this prescription while he was out of the country?

A. No.

Q. I think we have patient records regarding Patient D in '21.

Now, if you turn to the first page there, it's NSBME 0526?

A. Yes.

Q. What does that record say, what does it purport to be at the top of the page?

A. An interdisciplinary Team meeting note.

Q. If we go next to the page, 0252, is that the same note, or same type of note, type of record?

A. It is.

Q. Okay. You see Dr. Okeke signed in on that record?

A. Yes.

Q. What is the date of this record?

A. The first one is December 3rd, the second one is November 26, 2019.

Q. Do you know if Dr. Okeke was in the country on November 26, 2019?

A. I don't think he was.

Q. Okay. Are you familiar with signature stamps?
A. Yes.
Q. Does that look like a handwritten signature or a signature stamp? If you know or have an opinion.
A. I can't tell.
Q. Okay. Were you to able verify if other providers were actually treating Patient D while she was in the hospital at Sana Behavioral Health?
A. Yes, I believe there were other providers.
Q. So aside from this note on this interdisciplinary Team meeting, you don't see care for this patient attributed to Dr. Okeke?
A. No. It was, I guess, a primary physician they have listed in lots of the notes, is Dr. Lopez.
Q. Okay. It sounds like the fact that his name is on the prescription in 2020, perhaps, doesn't make sense and wouldn't be supported by him actually examining the patient?
A. Right.
Q. Let's turn to Exhibit 20 through -- no. Oh, actually, Exhibit 23, do you see any query done for Patient D by Dr. Okeke?
A. No.

Q. Okay. And if Dr. Okeke were to prescribe -- or did prescribe Suboxone to this patient, should he have queried her PMP history?

A. Yes.

Q. Then let's turn to Exhibit 25, and that's NSBME 0607?

A. Yes.

Q. Looking at this prescription, what are your thoughts on it?

A. Again, it was probably not written by Dr. Okeke.

Q. What is the date of this prescription?

A. November 15, 2019.

Q. Do you know if Dr. Okeke was out of the country on that day?

A. I believe he was.

Q. Did you review the medical records for Patient E that are in Exhibit 26?

A. Yes.

Q. And did you see the a reference to Dr. Okeke providing care to Patient E?

A. Yes. He was listed as the primary physician on some of the notes.

Q. Oh, he was?

A. He was, yes.

Q. Okay. On the note for -- this prescription is dated November 15, 2019, is there a record for that day that includes him?

A. I don't believe so.

Q. Okay. If we look at the utilization report for Patient E, this is Exhibit 29.

A. Yes.

Q. And if we look at the November -- we're going to 29, NSBME 0751.

A. Yes.

Q. Do you see two prescriptions on November 15, 2019?

A. Yes.

Q. Who were those written by?

A. Dr. Okeke and Debra Perkins.

Q. Okay. So it appears there was a second prescription on that same day for this patient?

A. Right.

Q. And is Debra Perkins mentioned in the treatment records?

A. I believe she was.

Q. Okay. Oh, let's go back to 28, that is the query history for Patient E, Exhibit 28, NSBME 0748.

Do you see a query being completed by Dr.

Okeke for Patient E?

A. No.

Q. And would it be the standard of care to prescribe for Patient E and not query when providing -- let's look at what the drug was again -- a prescription for Klonopin?

A. No.

Q. Okay. I think we talked about the records for Patient A. I think you identified some similar errors for Patient B. Patient B's medical records are Exhibit 14.

Just for the record, on Exhibit 14, 0409, what's the date of that visit on that page?

A. March 4, 2020.

Q. Okay. Then if we turn to the very back of the exhibit and go to page 0508, what is the date of that record?

A. 8/28/2018.

Q. Okay. We have records, it looks like, for a couple of years here?

A. Yes.

Q. And you reviewed all these records?

A. I did.

Q. And did you have some of the same concerns that we previously talked about with regard to

Patient A in these records?

A. I did.

Q. Okay. For example, if we go to NSBME 0421, which is kind of towards the front of the --

A. Yes.

Q. Okay. So you see the chief complaint?

A. Yes.

Q. Okay. And that verbiage, I think -- do you see that repeated in other -- oh, maybe not that one.

How about 0429?

A. Okay.

Q. And then if we look at the chief complaint there, and we look at 0433, are those identical?

A. Yes.

Q. Do you have the same confusion regarding the current medication lists for Patient B? Like, for example, if we go to -- for example, go to a visit dated February 5, 2020, and if we go to NSBME 0414, do you see multiple prescriptions there listed for Valium?

A. Yes, there's a couple.

Q. Okay. If we go to the treatment medication, it looks like the treatment medication starts on 0415 and 0416, those are -- it looks like

there was only one Valium that was actually being taken by that patient?

A. Right.

Q. So similar to Patient A, if you were to resume care or take over care for Patient B, would you feel like these records would give you an accurate picture of the medications he was taking, his symptoms, and his treatment plan?

A. No. I would just wonder if there were other medications on the current medication list that they should be taking.

Q. Okay. And if the current medication list has medications that are outdated and not controlled substances, how would you be able to determine what the patient was taking?

A. I guess you couldn't.

Q. You'd have to ask the patient -- right? -- and hope they remember, that what they give you is accurate. If they are controlled substances, you could at least look at the PMP and see what the current prescriptions have been filled?

A. Right.

Q. Okay. Do you believe that, then, the medical records for Patient B as maintained by Dr. Okeke meet the standard of care?

A. No.
Q. Okay. What is a patient/physician relationship?
A. A patient/physician relationship is, of course, the physician evaluating, doing an assessment on the patient, and then coming up with a treatment plan and prescribing.
Q. Okay. And you would make sure you had that before prescribing controlled substances; is that correct?
A. Yes. I guess unless there was a case I was covering for a colleague.
Q. Okay. What's your biggest concern regarding Dr. Okeke's care of Patient A?
A. Just the lack of checking the PMP, admits complaints from a family member or some concerns, and then there wasn't accurate reasoning behind why prescriptions were changed from month to month as far as the increase in dosage of the Klonopin and the switch from methylphenidate to Adderall.
A. And it sounds like she was taking a benzodiazepine, which is Klonopin, for a long time.
Q. Is that what you would do for a patient with chronic anxiety?
A. Unfortunately, there are lots of patients

that come inherited being on benzodiazepines for a long time. But I still feel like it's warranted that a discussion take place about getting off of benzodiazepines or at least trying to taper down.

Q. Would that be documented in the records, that conversation?

A. Yes.

Q. Okay. And your goal, it sounds like, would be not to keep them on benzodiazepines for a long period?

A. That would be the goal. But, unfortunately, some patients are very difficult to get off of these medications.

Q. Okay. And if you had a difficult patient, would you note that in the records?

A. I would have noted that we've had the discussion to work on another plan for long-term anxiety control.

Q. Okay.

MS. BRADLEY: I have no further questions for Dr. Chen at this time.

HEARING OFFICER HALSTEAD: Mr. Agwara, cross-examination?

MR. AGWARA: Yes. But I need make sure that we will finish this up. I believe Dr. Chen

goes up to 3:30.

MS. BRADLEY: Yes.

MR. AGWARA: Okay. Would it be a problem if we didn't finish, would we have to stop?

MS. BRADLEY: We have Dr. Chen calendared tomorrow also from 1:30 to 3:30, so it's possible that we could continue testimony -- or cross-examination on this case during that window.

I don't think my direct tomorrow will take as long because I only have one patient in tomorrow's case. We may be able to bifurcate it. Alternatively, we do have time reserved on November 21st, that I believe she's blocked for us as well. That was our backup day if we didn't finish.

We have those two options if we don't finish at 3:30.

MR. AGWARA: Okay. So may I make a request if it's okay to do our cross-examination either tomorrow or on the 21st of November? I don't want to start and stop. There's a lot that I want to go through, especially with the records.

HEARING OFFICER HEALSTEAD: I want to use our time wisely. I would like to use the time today we have today and then we can do tomorrow for the rest of what we have today. And then we can use the

November date for the case we have tomorrow, if need be.

MR. AGWARA: With that said, I need about ten minutes to use the restroom, and then consult my notes before I start.

HEARING OFFICER HEALSTEAD: Yeah, do you want to come back at come 3:10?

MR. AGWARA: Yes.

HEARING OFFICER HEALSTEAD: We will take a break until 3:10.

(Recess from 3:00 p.m. to 3:10 p.m.)

HEARING OFFICER HEALSTEAD: Were back on the record In the Matter of Charges and Complaint Against Matthew Obim Okeke, M.D. We took a break just before commencement of the cross-examination by Mr. Agwara on behalf of Dr. Okeke. It is now 3:12.

It is your witness, Mr. Agwara.

MR. AGWARA: Thank you.

CROSS-EXAMINATION

BY MR. AGWARA:

Q. Dr. Chen, have ever had private patients of your own?

A. Yes.

Q. Okay. So you did work in a private clinic?

A. Yes. I do work in a clinic currently.
Q. Is it a private clinic?
A. What do you mean by "private clinic"?
Q. Is it privately owned by either one doctor or a group of doctors?
A. It's not owned by a doctor, per se.
Q. Okay. But it's not owned by you?
A. No.
Q. Do you have any ownership interest?
A. No.
Q. Okay. It is a hospital that you work at?
A. I do work at a hospital as well.
Q. Okay. So when you're at the hospital, do you guys get private patients who are brought in for some -- for whatever reasons?
A. Yes.
Q. When you have those patients, can you run PMPs on them even though they are not your patients?
A. If they are not our patients, no.
Q. Okay. The reason I ask you that -- we're going to go through a lot of records. The exhibits, 17, 20, and 25, are the handwritten prescriptions that Ms. Bradley had you testify about. We're going to go back to those.
Let me ask you generally, do you know what

Sana is? S-A-N-A.

A. It looks like it was like a hospital or detox; right?

Q. Yeah, it was hospital.

Do you know who their medical director was?

A. No.

Q. Would you be surprised if I told you it was Dr. Okeke?

A. No.

Q. Okay. Do you know what the role of a medical director is?

A. Yes.

Q. Okay. Do you believe that medical director has to be present when patients are seen at that hospital?

A. No.

Q. Okay. Was it your opinion that the patients that you testified about, Patients A, B, E and I believe D, I'm not sure. Do you -- first of all, do you have any evidence that those were Dr. Okeke's patients?

A. I believe Patient A was; right? I don't think she was in the hospital.

Q. Okay. What is the evidence that leads you

to believe that?

A. If Patient A -- let's see.

Her records were Exhibit 7; correct?

Q. Let's see, Exhibit 7.

So your testimony is it's the medical records that lead you to believe that Patient A was Dr. Okeke's patient; correct?

A. Yes.

Q. How about Patient B?

A. Which exhibit it that again?

MS. BRADLEY: Patient B's medical records are Exhibit 14.

MR. AGWARA: Thank you, Ms. Bradley.

THE WITNESS: Patient B, there are records that that's Dr. Okeke's patient as well.

BY MR. AGWARA:

Q. Okay. How about the remaining patients?

A. I believe one of the patients the attending or the primary physician was Dr. Lopez. There was one where Dr. Okeke was the primary physician on the notes. I can't remember which exhibits corresponded to which patients, though.

Q. You don't have in your notes which patients were his and which ones were not?

A. Not in front of me, no.

Q. Is it your testimony that three of the five patients were his?

A. Yes. I can see -- I mean, I know their names, I know we're not supposed to use the names, so I just don't remember which patient are which exhibits.

Q. Okay. Let's talk about as the two what weren't his patients, and do you know if they are C, D, or E?

A. Again, it was my fault, I didn't take notes on which exhibits corresponded to which patients. I guess there's Exhibit 21 where the psychiatrist is listed as Dr. Okeke in the interdisciplinary Team meeting note.

Q. Okay. Let's get to 21.

Do you see that the notes are from Sana?

A. They are from Sana. I guess I'm referring to 0525, where he's listed as the psychiatrist on the Team meeting note.

Q. Okay. And that to you means that this patient was his?

A. That's what I would assume.

Q. Do you see any records from any of his companies during that visit?

A. Again, this is the one where the rest of

the notes, the progress notes indicate Dr. Lopez was the doctor.

Q. So whose patient was it? Dr. Lopez or Dr. Okeke, in your opinion?

A. That, I can't really gather. It could have been Dr. Okeke's who transferred care. I don't know.

Q. Okay. And -- but you were comfortable opining that Dr. Okeke's care fell below the standard based on your review of this record?

A. Yes. Just based on the fact that he was on the interdisciplinary Team meeting notes, and there was a prescription.

Q. What is your understanding of the duties of a medical director?

A. They just kind of oversee the treatment of all the patients in the hospital.

Q. Do they work at the hospital or can they be employed elsewhere and just be a medical director?

A. They can be the medical director, but you would have to work with the hospital.

Q. How often?

A. It just depends on how often they are needed to oversee cases.

Q. Can they just attend meetings and review a few files once a week?
A. That is fine.
Q. That's acceptable?
A. Um-hum.
Q. That would not be below to standard of care, would it?
A. No.
Q. Do you have any evidence that that's not what happened here with this patient?
A. I don't have any evidence. I just wonder why he's listed as the psychiatrist.
Q. If he's a psychiatrist and he's a medical director, would there be a problem at their meeting to list him as a psychiatrist?
A. I guess not, no.
Q. Okay. Do you see that it does say "interdisciplinary Team meeting"; right?
A. Yes.
Q. Okay. This is not a patient's record or note?
A. Not a progress note.
Q. Okay.
A. In his record.
Q. So based on what you know now that he was

an outside medical director, are you still -- is it still your opinion that the care he provided with regard to this patient fell below the standard?

A. I guess I would just wonder why the prescription was written under his name.

Q. Okay. We're going to talk about that.

Other than the prescription, do you have any other problem with these -- with the role in this patient's care?

A. No.

Q. Okay. Let's talk about the prescription.

Do you know which one -- we have Exhibit 17, 20, and 25. Let's figure out which one it is.

MS. BRADLEY: Are you looking for Patient B?

MR. AGWARA: Well, whoever has the 21. Let me see.

HEARING OFFICER HEALSTEAD: I believe it's D, like dog.

MS. BRADLEY: The prescription is Exhibit 20 and the medical records are 21.

MR. AGWARA: And that matches the patient in Exhibit 21?

MS. BRADLEY: Yeah. 20 is the prescription and 21 is the medical records.

MR. AGWARA: Okay.

MS. BRADLEY: They are next to each other.

BY MR. AGWARA:

Q. Are you there, you have the exhibit?

A. Yes.

Q. Now, when a private patient is brought to a hospital, is the patient's private doctor required to be there?

A. No.

Q. If that doctor is not there and there arises a need to prescribe controlled substances for that patient, how is that handled?

A. In the hospital, you mean?

Q. Yes.

A. Another covering doctor if there's, like, an agreement, they could prescribe for the patient.

Q. Okay. And if that were to happen, how is that prescription handled?

A. I guess it would just depend on the procedures in the hospital of how to do a controlled substance.

Q. Could it be handwritten?

A. You could also -- yeah -- well, there would have to be a hard copy.

Q. Let's talk about this particular patient.

We all know that Dr. Okeke was not in the country, so there's no way he could have been there physically?

A. Right.

Q. So how do you explain the existence of this handwritten prescription that is not in his handwriting and not signed by him?

A. Yeah, someone else wrote the prescription.

Q. Could that somebody be someone at the hospital, or could it be the pharmacist that wrote down an order?

A. It could be either, I guess.

Q. Okay. Do you have any evidence that Dr. Okeke wrote this prescription?

A. No.

Q. Okay. But you testified that because of the fact that this prescription has his name, that care fell below the standard, didn't you?

A. I imagine it was authorized by him.

Q. You mean you assume?

A. Yeah.

Q. Okay. Now, assuming he authorized this either through another provider or through a phone call from overseas, what would be the problem in 2019 calling in this prescription?

A. I just don't know why he would be on the prescription and not the provider, that was the patient on discharge.

Q. Now, is it your experience that when a private patient is taken to a hospital, the attending physician or the attending physician's name is put on the prescription as the patient's doctor for purposes of payment?

A. I don't understand your question.

Q. Okay. Let me carefully rephrase that.

If a private patient is taken to a hospital, seen by a provider that is not their doctor and that provider has to call in a prescription for Schedule 3 and 4, -- I'm going to ask you in a minute what schedules these are -- and the pharmacy handwrites that call-in order, whose name do they put on the prescription as the physician for that prescription?

A. I would assume the -- it should be the doctor who saw them in the hospital.

Q. Okay. Now, are you aware that a lot of times, if not all the times, that the pharmacy would put down the doctor that they have for that patient that is their primary doctor?

A. I guess that would be -- yeah -- on the

pharmacy.

Q. Okay. I missed that.

A. I would hope that the pharmacy would do a more thorough job of documenting who is giving the prescription.

Q. Okay. Now -- and does it make a difference to you or does it explain why there were no PMPs run if this patients were seen at the hospital and the patients were not their attending physician's patients?

A. Yes, that makes sense.

Q. Would you consider that before you gave your opinion about Dr. Okeke's care falling below the standard?

A. No. I mean, that didn't occur to me.

Q. Okay.

THE WITNESS: I have patients myself to see. I really apologize for bringing your awareness to --

MS. BRADLEY: Yeah. It's 3:29. So thank you, Dr. Chen.

THE WITNESS: Thank you. Sorry.

MR. AGWARA: That's why I didn't really want to get going. We have a lot more to talk about. That's fine.

HEARING OFFICER HEALSTEAD: Thank you, Dr. Chen. We will see you tomorrow at 1:30.

(The witnesses left the hearing.)

HEARING OFFICER HALSTEAD: Mr. Agwara, I anticipate that you will continue your cross of Dr. Chen at 1:30 in this case before we move on to another. And then if we need her for the case we're doing tomorrow, we can always do that on the November date.

MR. AGWARA: Okay. That's fine.

But in the morning, we're going to do the other witnesses for the new case; right?

HEARING OFFICER HEALSTEAD: Correct.

And then -- Ms. Bradley, do you have any other witnesses?

MS. BRADLEY: Not for this case. And I do have a couple redirect, so far, based on what he's asked.

HEARING OFFICER HEALSTEAD: Okay. Those will follow the finish of his cross --

MS. BRADLEY: Yeah.

HEARING OFFICER HEALSTEAD: -- when we do that tomorrow.

MS. BRADLEY: Okay.

HEARING OFFICER HEALSTEAD: So we're going

to have to go out of order at this point. I don't know -- I assume, Mr. Agwara, correct me if I'm wrong, you would like to finish with the expert before you need to call your client, because I would imagine would like to address what the expert testified to.

MR. AGWARA: Oh yes.

HEARING OFFICER HEALSTEAD: Okay. So with that, I'm not sure that there's much more we can do today, unless someone has any other suggestions for a good use of our time for the remainder of the day.

MS. BRADLEY: We could --

MR. AGWARA: I need the break, anyway. We've been going nonstop for three days. We could also use that time to try to get other things done in our offices.

HEARING OFFICER HEALSTEAD: Ms. Bradley, did you have a suggestion?

MS. BRADLEY: Well, I was thinking we could, if we wanted, start tomorrow's case with witness -- I have witnesses that are prepared to testify in case number 3 tomorrow morning.

I think that Mr. Diaz may be available if we wanted to start case 3. I don't know if that's too confusing to do.

HEARING OFFICER HEALSTEAD: Well, I'm okay with that, but only if Mr. Agwara is okay with that, because I'm sure -- and I don't want to speak for him -- he planned on handling that tomorrow, so I don't know if he's had a chance to fully prepare for that case. That might be something he was going to do tonight.

MR. AGWARA: Thank you. That is exactly -- I mean, I cover several areas of law. I got a client and an office full of people waiting for their checks. I need to take care of those. And then sometime, maybe around midnight tonight, start preparing for tomorrow's case.

HEARING OFFICER HEALSTEAD: Okay. With that, I think what we should do is break for the day, we'll start the -- what matter are we starting tomorrow, Ms. Bradley?

MS. BRADLEY: The new matter is 24-22461-3, but I think -- oh, I see. We would do that in the morning, call her at 1:30 and then go back to this case, and then finish this case. I'm trying to process in my own head how this would go.

HEARING OFFICER HEALSTEAD: Hopefully we would finish this case. We could start the new case in the morning, hopefully finish this case in the

afternoon, and then finish the case we started in the morning on the November date.

MS. BRADLEY: Okay.

HEARING OFFICER HEALSTEAD: Does that work for everybody?

MS. BRADLEY: Yeah. And we may -- I don't know if he intends to use the entire two hours for cross-examination, it may not be fair to her to switch cases, but I was going to say I don't think I have a lot of direct for her, it's just one patient, and so we could try to get some direct in on the new case tomorrow at 1:30 after he finishes cross. I don't know if that's fair, though, to do.

HEARING OFFICER HEALSTEAD: I would like to use our time effectively, so if she's here and on the one case, then we'll continue to the next case. That's already scheduled for tomorrow and that's when she would have been testifying to that day anyway.

MS. BRADLEY: Yeah. She's got the time scheduled for us, and I know she's reviewed all the documents.

MR. AGWARA: Okay. So she's going to be the witness, the expert for tomorrow also?

MS. BRADLEY: Yes. She's the expert in 1,

2, and 3, yeah.

MR. AGWARA: How many other witnesses do you have?

MS. BRADLEY: I have Ms. Zarley and Mr. Diaz.

HEARING OFFICER HEALSTEAD: For tomorrow's case?

MS. BRADLEY: Yeah, those are who are scheduled tomorrow.

MR. AGWARA: Well, we may be able to get both of them done.

MS. BRADLEY: Yeah. It depends. I only have -- I guess I have four pages of questions, but that's a lot less than I normally would have on a direct.

HEARING OFFICER HEALSTEAD: Since we're losing time today, I would prefer to start at 8:00 tomorrow. Doesn't anyone have a problem with that?

MS. BRADLEY: I don't.

MR. AGWARA: My staff doesn't get here until 8:00, so --

MS. BRADLEY: I'd have to check my first witness to make sure he's available. And then Ms. Zarley in case we got to her before 8:30.

MR. AGWARA: I drop my daughter off just

before 8:00 before I start driving, so I'm going to be late.

HEARING OFFICER HEALSTEAD: We won't change it. I'm trying to get us through.

MS. BRADLEY: I understand.

HEARING OFFICER HALSTEAD: Another thing, I might as well address it now. These are several cases and I have 30 days to issue findings of facts, and I don't think I can effectively do this many cases with the details in 30 days.

MS. BRADLEY: I think you, technically --

MR. AGWARA: We can waive that. It is up to us? If it is, yeah, give you the time.

MS. BRADLEY: I think, technically, you have 60, is my memory of the statute. But this matter is not -- I mean, we didn't think we could get it done by the December board meeting. We're anticipating it will go on the March board meeting, so that means you have until January, most likely.

HEARING OFFICER HEALSTEAD: Okay. Because I'm gone the last two weeks of December.

MS. BRADLEY: Yeah. And so you have -- and normally I think we give you 60 days from the hearing, that is our normal time frame that I'm aware of.

Again, we don't want you to stress and we want you to get it done and we know you will.

Usually, we try to have documents ready for a board meeting -- we might even be able to go February 1st for the March board meeting.

MR. AGWARA: I've already made my position known. If you need more time, I have no opposition to it. I don't think the Board will either.

HEARING OFFICER HEALSTEAD: All right. Thank you. We're on the record, so I will note that everyone has waived the time limit for order. I don't know if you have a preference, so tell me. I would do -- my plan is -- and I don't know if this is logistically correct -- I would do one order addressing each case individually.

MR. AGWARA: Yes.

MS. BRADLEY: That's what we're anticipating you will do.

HEARING OFFICER HEALSTEAD: I'm just making notes of this.

MS. BRADLEY: Because there were separate complaints, I was picturing separate recommendations regarding each one.

HEARING OFFICER HEALSTEAD: I could one document with findings for each case; correct?

MS. BRADLEY: Yeah. I don't have an objection to that, to them being in one document. But, yes, I was picturing them being done one by one.

We most likely will put them on the same board meeting. How we agendize that, I don't quite know yet, but probably it will be all together.

HEARING OFFICER HEALSTEAD: Okay. Is there anything else that we can address before we stop for the day?

MR. AGWARA: Nope.

HEARING OFFICER HALSTEAD: Yes, our court reporter has something then.

THE REPORTER: What is the means for our meeting tomorrow? Are we staying on Zoom tomorrow?

HEARING OFFICER HALSTEAD: I would prefer that we -- we're not all going back and forth. It's easier to stay on Zoom, but I'll defer to the parties for what they prefer on that.

MR. AGWARA: I think Zoom is better because I believe the court reporter can also hear us better.

THE REPORTER: Way better, yes.

HEARING OFFICER HALSTEAD: Ms. Bradley, you're fine with that?

MS. BRADLEY: That's fine with me. We have a link for that. I think it's the same link we're using right now.

HEARING OFFICER HALSTEAD: I want to summarize what we've covered.

We ended during Mr. Agwara's cross of Dr. Chen on that matter number 2. Tomorrow we will commence again at 8:30, and we'll start with matter 3. And then we'll do matter 3 in the morning. We'll finish with matter 2 and Dr. Chen in the afternoon, and we will also address matter 3 with her if we get through matter 2. She will be taken out of order --

MS. BRADLEY: Yeah.

HEARING OFFICER HEALSTEAD: -- if we don't finish what we need to finish for 3 in the morning. Then if we have anything left, we'll do on the November date.

MS. BRADLEY: Yes.

HEARING OFFICER HEALSTEAD: And then the parties have waived my time limit to do findings. I'll do one document breaking out each of the findings for each case.

MS. BRADLEY: Yes.

HEARING OFFICER HEALSTEAD: Anything that

I missed?

MS. BRADLEY: I don't believe so.

HEARING OFFICER HEALSTEAD: Mr. Agwara, anything you want to add to that?

MR. AGWARA: No.

HEARING OFFICER HEALSTEAD: Okay. Then with that, I will see you all at 8:30 in the morning, and the Board will send out the link for the Zoom call tomorrow.

MR. AGWARA: Okay.

HEARING OFFICER HALSTEAD: All right. Thanks, everyone.

(Hearing adjourned at 3:41 p.m.)

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

I, BRANDI ANN VIANNEY SMITH, do hereby certify:

That I was present on October 23, 2024, for the hearing via Zoom, and took stenotype notes of the proceedings entitled herein, and thereafter transcribed the same into typewriting as herein appears.

That the foregoing transcript is a full, true, and correct transcription of my stenotype notes of said proceedings consisting of 151 pages, inclusive.

DATED: At Reno, Nevada, this 11th day of November, 2024.

/s/ Brandi Ann Vianney Smith

_____

BRANDI ANN VIANNEY SMITH

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

FILED

NOV 18 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

In the Matter of the Charges and Complaint Against:
MATTHEW OBIM OKEKE, M.D.,
Respondent.
_____/

Case No. 24-22461-2

TRANSCRIPT OF HEARING PROCEEDINGS

Held via Zoom

Thursday, October 24, 2024

Reported by: Brandi Ann Vianney Smith
Job Number: 6728094

A P P E A R A N C E S:

THE HEARING OFFICER:	PATRICIA HALSTEAD, ESQ.
FOR THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS:	SARAH BRADLEY, ESQ. Deputy Executive Director Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, NV 89521
FOR RESPONDENT:	LIBORIUS AGWARA, ESQ. Law Offices of Libo Agwara Ltd. 2785 E. Desert Inn Road, Ste. 280 Las Vegas, NV 89121

ALSO PRESENT:
Valerie Jenkins, Legal Assistant

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I N D E X

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RENO, NEVADA -- OCTOBER 24, 2024 -- 1:31 P.M.

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HEARING OFFICER HALSTEAD: We're back on the record in matter 24-22461-2, In the Matter of Charges and Complaint against Matthew Obim Okeke, M.D.

We undertook this matter yesterday, and we took a break for scheduling purposes. We are now back on the record and we're commencing with where we left, which was respondent's cross-examination of Dr. Chen, who is the IC witness.

Dr. Chen, you were sworn in yesterday, and I could remind that you are under oath, but I prefer that you just raise your hand and be re-sworn.

(The oath was administered.)

HEARING OFFICER HALSTEAD: Thank you. Will you please state and spell your name for the record.

THE WITNESS: Jayleen Chen, J-A-Y-L-E-E-N C-H-E-N.

HEARING OFFICER HALSTEAD: Okay. Thank you.

Mr. Agwara, are you prepared to continue

with your cross-examination?

MR. AGWARA: Yes.

HEARING OFFICER HALSTEAD: Thank you. Please proceed.

CROSS-EXAMINATION (continued)

BY MR. AGWARA:

Q. Dr. Chen, I want to make sure, there are certain things that we talked about yesterday, that's why I asked the additional questions.

I believe we established before we broke yesterday that two or three of the patient's that we're dealing with here were not Dr. Okeke's patients. I don't know which ones, but I believe at least two of them were not; is that correct?

A. I believe so, from the ones that were in the hospital; right?

Q. Yes.

A. Okay.

Q. You also recall that he was overseas during the visits that we have as part of our records here; is that correct?

A. Yes.

Q. Okay. So with respect to those patients, are you still maintaining that his care of them fell below the standard?

A. I guess -- from I reviewed, I thought that he was acting as the attending physician.

Q. Now that you know that he's not, are you changing your opinion?

A. I guess if he was the medical director, I could see that being okay.

Q. Okay. All right.

Let's talk about Patient B. Let me direct your attention Exhibit 12.

HEARING OFFICER HALSTEAD: Mr. Agwara, can I ask a clarifying question for my understanding?

MR. AGWARA: Sure.

HEARING OFFICER HALSTEAD: Thank you.

Dr. Chen, you said if he was the medical director then you can see it being okay. What is "it," what specifically are you saying is okay?

THE WITNESS: The care was under another doctor, but being the medical director, you don't have to be there to provide care. You just have to oversee the care and provide supervision or oversight of the patient care.

And I guess that could have been fine if he were to staff the patient when he had the opportunity to, I guess.

HEARING OFFICER HALSTEAD: Thank you for

clarifying that.

Thank you, Mr. Agwara.

MR. AGWARA: I believe, Ms. Bradley, this is Patient B, Exhibit 12?

MS. BRADLEY: Exhibit 12 is Patient B, yes.

MR. AGWARA: Okay.

BY MR. AGWARA:

Q. Now, Dr. Chen, did you have a problem with this prescription signed by Dr. Okeke?

A. Yes. It appears that was when he was out of the country.

Q. Okay. Do you know what time he left the country?

A. I don't know recall those specifics.

Q. Okay. Let's talk about that. Let me see if I can remind you.

MR. AGWARA: He left the country on November 8, 2019. I believe that is what we stipulated to?

MS. BRADLEY: We stipulated to the fact that he left at 11:45 p.m. on November 8, 2019.

MR. AGWARA: Thank you.

BY MR. AGWARA:

Q. Now, Dr. Chen, do you have any reason to

believe that Dr. Okeke did not go into work that day?

A. No.

Q. Okay. So if I told you he was at work that day and that he signed this prescription that day before left at almost midnight, would you have any reason to not believe that?

A. No.

Q. Okay. And on the basis of that information, do you still have a problem with this exhibit, this prescription?

A. No.

Q. Okay. Thank you.

I didn't hear you correctly yesterday, but did you testify that a physician could not delegate to another physician or to another employee an employee to call in our fax in a prescription back in November of 2019?

A. Not for a controlled substance.

Q. Now, if it was a Schedule 3 or 4, would it make a difference?

A. I believe you were supposed to have a hard copy of those as well, for all scheduled.

Q. Do you know when the rule changed calling in prescriptions?

A. I just know that everything turned electronic for prescribing substances.

Q. And as of November 2019?

A. That, I am not aware of. If it was -- you would still have to fax over a hard copy.

Q. Anyway, let's talk about Patient A. I believe that's the one you spent the most time on on your direct.

A. Um-hum.

Q. You looked at several visits and the notes and you testified -- let me ask it this way: What were the concerns you had about Dr. Okeke's care of Patient A?

A. I believe that the biggest concern was I don't feel he was checking the PMP. She had a lot of medications that could be misused or abused or could interact with each other to have very negative side effects.

There was concern about the documentation not being understandable as far as medical decision-making, and just a lack of diligent documentation was a big one.

Q. What is your understanding of long-term care?

A. Long-term care, just seeing the patient

for more than a couple visits.

Q. Three visits would qualify for long-term care?

A. I would probably say -- there's really no definition. I guess it's a subjective definition.

Q. So the big problem you have in the care of Patient A was documentation and PMP queries; is that correct?

A. Yes.

Q. I believe we established yesterday that it is not okay for a physician to query the PMP of a patient that is not his; is that correct?

A. Yes.

Q. Okay. And that may explain why those patients what were in the hospital, we see prescriptions without queries being done because those patients were not there; is that correct?

A. Yes.

Q. I was going to make you go through all the exhibits counsel took you through yesterday, but I don't really think this is necessary.

MR. AGWARA: I'll turn over the witness.

HEARING OFFICER HALSTEAD: Go ahead, Ms. Bradley.

MS. BRADLEY: Thank you.

REDIRECT EXAMINATION

BY MS. BRADLEY:

Q. We've been talking about whether or not a patient is yours, and I guess I just want to ask some clarifying questions around that because I'm a bit confused.

You testified about working in the hospital. If a patient comes in in the hospital while you're working, you never seen that patient, before and you prescribe medication for them, do they not become your patient?

A. I'm trying to think of an example. So I guess in my particular hospital, if they are admitted, they are admitted to an attending physician. If that is not myself, then I'm not the treating physician.

There could be a chance where I interact with that patient, whereas I might be covering for a colleague who is out or I might have to write the discharge orders for the patient and discharge medications, but I would have to see the patient before they discharge. Our specific hospital, the patient has to be seen within 72 hours of discharge by the physician.

There have been times where a prescription

doesn't go through, so after discharge, the pharmacy will call me to help clarify the prescription. That is where I could potentially prescribe, having not seen the patient, since I do cover a colleague on certain days that they are not working.

Q. Okay. But in the file, would there be information for you to review such as the PMP?

A. There should be. And then in that case, if I did have to do something that was a scheduled medication, I could query the PMP, since I am filling that prescription.

Q. So you could query. Do you think it's required for you to query before you do a controlled substance for that person?

A. Yeah.

Q. I don't know if your situation is like an emergency room. What kind of hospital is it?

A. I work at a residential treatment center for adolescents.

Q. Because I could foresee situations where somebody could go to the emergency room, who might even be drug seeking, and if they weren't queried, that could be very dangerous?

A. Right.

Q. So the hospital setting doesn't prevent

you from querying a patient's PMP history?

A. No, it doesn't.

Q. Okay. But it sounds like if you're covering for someone else, you might review their file and their work and rely on that in what you do next?

A. Right.

Q. Okay. Let's talk about Patient B again. I think there's maybe some -- we've had a day in between, and I think -- if we look Patient B, the prescription is in Exhibit 12. And I believe this is all on the record from yesterday, but because the cross just now addressed it, I feel like I have to redo it.

Suboxone is a controlled substance; right?

A. Yes.

Q. Okay. And I believe you testified that you would not prescribe a controlled substance without seeing the patient, and so even if he actually wrote this prescription, would you have a concern if there was not a medical record that went along with this November 8, 2019, date?

A. Yes.

Q. Okay. So let's turn to Exhibit 14, and if you look at -- if you look at Exhibit 14, NSBME 0 --

NSBME 0425, do you see the date on that record?

A. Yes. October 10, 2019.

Q. Who is the attending physician for that day?

A. Dr. Okeke.

Q. Then if we go forward one, we see a record for November 15, 2019, on page 0421, do you see who the attending physician or attending person is on that day?

A. Debra Perkins.

Q. Do you see a visit with Dr. Okeke in these records that correlates with the prescription date of November 8, 2019?

A. No.

Q. I believe you testified -- or I believe we talked about this before, it seemed likely that he provided the prescription to the patient on the 10th with the date of November 8th. Does that sound reasonable?

A. What was that? I'm sorry.

Q. That, perhaps, he provided the prescription to the patient on October 10th when he saw the patient, but he dated it for November 8, 2019, because there's no visit for November 8, 2019?

A. Right.

Q. Then if we go to Exhibit 4, which is his response to the Board, NSBME 0011, do you see the top, the number 1 there?

A. Yes.

Q. Okay. That's regarding Patient B.

Do you see where it says, "I gave him"?

A. Yes, I do.

Q. Okay. Actually would you read the two sentences? The first one starts with "I saw," and then the second one, "I gave him."

A. "I saw this patient October 10, 2019, and he saw another provider in my office November 15, 2019. I gave him a script for the date I saw him, and I did not postdate any script for him."

Q. Do you think that statement is accurate based on the records you've reviewed?

A. No.

Q. And is that your concern with this prescription for Patient B?

A. Yes.

Q. All right. Then going back to Patient A, it's not -- I mean, part of the documentation concern I believe you talked about and I just want to clarify, is the change in prescription meds; is that right?

A. Yeah, that was an issue.

Q. And I think Dr. Okeke at this point through his attorney is trying to maybe -- and I get it -- have a defense, minimize documentation, but do you think maintaining appropriate records is important?

A. Yes.

Q. Is it a minor thing to not fully document the care of a patient in their records?

A. No.

MS. BRADLEY: I have no further questions.

HEARING OFFICER HALSTEAD: Okay. Anything further for this witness before we move on to the matter?

MR. AGWARA: Yes, ma'am. Actually, two -- let's see.

RECROSS-EXAMINATION

BY MR. AGWARA:

Q. If we could go Exhibit 17, 20, and 25. Let's start with 17.

Now, you see on the -- this is a prescription when the patient -- on the date that Dr. Okeke was overseas. We've established this is not one of his patients, or if it was, he wasn't there.

This was a hospital. Do you see the line where it says "address"?

A. Yes.

Q. What is the entry on that?

A. "Discharge Sana."

Q. Sana is a hospital. And Dr. Okeke was the medical director, and it looks like another provider is discharging this patient; correct?

A. Yes.

Q. And writing this prescription.

So this has nothing to do with Dr. Okeke; right?

A. Right.

Q. Now let's go to 20. Now, 20, as you can see, also is a handwritten prescription; correct?

A. Yes.

Q. And on that address, it also says "Center" something, I don't what the other thing is?

A. Um-hum.

Q. And it looks like somebody else handled this, and of course since he was overseas, he had nothing to do with this.

Now, I think you've already testified that now that you know that he was just a medical director, that you don't have a problem with

whatever role, if any, that he may have played with respect to these exhibits -- correct? -- the handwritten prescriptions.

A. Yes.

Q. Okay. Then let me not waste everybody's time going through that.

Now, assuming that, as counsel stated or implied, Dr. Okeke saw Patient B in October and gave the patient a prescription dated November 8, what reason would he have to do that? Can you think of think reason why he would have do that?

A. The question again?

Q. I think Ms. Bradley asked you if it was your opinion that, because Dr. Okeke saw Patient B in October, I don't know the exact date, maybe 15th -- oh, the 10th, okay -- that perhaps he wrote the prescription dated November 8th during that October visit, and I think you agree that that may have been what happened.

Assuming that that's even what happened, what would be the problem with that?

A. It's just not the right date.

Q. Okay. And it's not okay to postdate?

A. Not -- with -- I guess like we talked about, I mean, it's another case, but you have to

write "do not fill until" if you want to postdate a prescription for a controlled substance.

Q. And the basis for the belief that he may have written that on October 10th is because there's no note, no record for that date?

A. Yes.

Q. Okay. And are you -- I mean, I'm trying to phase my questioning in a way that will be clear.

Does the lack of the record, for whatever reasons, maybe because it wasn't produced or somebody overlooked it, does that absolutely establish to you there was no visit that day?

A. No. But I imagine they got all the records.

Q. Okay. Thank you.

MR. AGWARA: That's all I have.

HEARING OFFICER HALSTEAD: Ms. Bradley, your witness, you have final crack if you want it.

FURTHER REDIRECT EXAMINATION

BY MS. BRADLEY:

Q. I would just like to have Dr. Chen tell us more about the requirements for postdating a prescription?

A. Back then when we were prescribing controlled substances, especially Schedule 2

medications, we could write three prescriptions on the same date with postdates on two of prescriptions for do not fill until the next month of whatever day that we wrote the prescription and then the month after that, essentially giving a three months' worth of medication at one visit.

Q. Okay. And so it sounds like there's -- if we were to summarize, there's three requirements regarding those. The first one would be the date that it was actually written, the second one would be to say "do not fill until" on two of them, a max of two, and then the date it is not to be filled until?

A. Yes.

Q. You don't see that on Exhibit 12?

A. No.

MS. BRADLEY: I have no further questions for Dr. Chen in this case.

HEARING OFFICER HALSTEAD: I have a clarifying question and then you can both follow up if need be, but I want to understand what I understand your testimony to be.

So when we're looking at Exhibit 17 and 20, those were both prescriptions that were called in and written by a pharmacist, we're assuming, on

dates that Dr. Okeke was not in the country, and as I understood your testimony on cross-examination, was even though he was not the treating physician, it's okay for his name to be placed on them because he was director.

So he didn't need to be the treating physician to have his name on these prescriptions. Is that your testimony?

THE WITNESS: I think that we had gotten maybe the pharmacist had made a mistake. I still would not have his name as the provider on that prescription. I would want for the prescriber who was seeing him in the hospital to be on the prescription.

HEARING OFFICER HALSTEAD: You're attributing that to a pharmacist's mistake now?

THE WITNESS: I imagine that's what we were speculating that it could be.

HEARING OFFICER HALSTEAD: Well, we're not speculating. No one is speculating here. I don't want any speculating.

His name is on those prescriptions, and I need to make a recommendation to the Board whether or not that implies he did something wrong, and I need you to help me do that. I don't want you

speculating, I want you to tell me if that is a problem or not. For him, not for the pharmacy?

THE WITNESS: If he was the medical director, I would think it would be okay.

HEARING OFFICER HALSTEAD: Okay. Thank you.

Any follow-up based on my questions?

MS. BRADLEY: Not from me. Thank you.

MR. AGWARA: Not from me either.

HEARING OFFICER HALSTEAD: Thank you.

All right. I'm going to take a couple of notes, and then we will move on to the other matter. We will go off the record for matter 2, then as soon as I make these notes, we'll move on to matter 3.

(Recess from matter 2.)

HEARING OFFICER HALSTEAD: We're back on the record on case number 24-22461-2, In the Matter of the Charges and Complaint against Matthew Obim Okeke, M.D.

Last we dealt with matter, the IC, by and through Ms. Bradley, had finished with their witness Dr. Chen.

Ms. Bradley, do you have any further witnesses?

MS. BRADLEY: I do not.

HEARING OFFICER HALSTEAD: And does the IC officially rest its case in matter 2?

MS. BRADLEY: We do.

HEARING OFFICER HALSTEAD: Thank you.

Mr. Agwara, does your client intend to call any witnesses on his behalf of with respect to matter 2?

MR. AGWARA: No.

HEARING OFFICER HALSTEAD: Likewise, your client will not be testifying?

MR. AGWARA: No.

HEARING OFFICER HALSTEAD: Okay. And so with that, both parties rest; correct?

MS. BRADLEY: Yes.

MR. AGWARA: Yes.

HEARING OFFICER HALSTEAD: And then we will move to closings.

Ms. Bradley?

MS. BRADLEY: Thank you.

CLOSING STATEMENT

MS. BRADLEY: In this matter, we alleged violations of the standard of care for treatment of five patients. I'm going to start with Patient A because I think we spent the most time with regard to Patient A.

First, there are concerns regarding the accuracy of the records for Patient A, and I think that's replete throughout those records. We spent a lot of time in the Complaint actually going through and listing out the medications that were listed as current medications for Patient A and the fact that those are concerning and confusing because there's multiple strengths of the same medication, some medications that treat the same condition, and so a provider that maybe were to take over the care would not be able to rely on the current medication list for Patient A in this case.

But I think most importantly, Dr. Chen said it several times, is the fact that Dr. Okeke did not check the PMP for Patient A. Patient A was taking both benzodiazepines and opioids at the same time, which there is a lot of concern about because that could case respiratory depression, it can actually case death.

In this case, Dr. Okeke was providing the benzodiazepines, he was not providing the opioids, but he would have known about the opioids if he had conducted a query of the PMP, and he did not do so. At a minimum, I think the law establishes the standard of care with regard to checking the PMP.

It's required by law. In this case, it was not done, there was treatment for quite a bit of time.

The treatment started in -- I believe it started in 2013, and then the treatment went through 2019. I think most of the treatment -- obviously, the January 1, 2018, is when the PMP queries were required, and there were 20 visits that we talked about during that time period. There was one visit a month in 2018, and then about seven visits in 2019 that we talked about. And there was not any querying done at that time. And, again, the patient was taking the benzodiazepine at the same time as an opioid, which leads her to possible harm. And that's why it's so important that the PMP be checked, because the standard of care requires that. And the standard of care requires that if a patient is taking both at the same time, that that be noted in the record as well as decisions made. I think Dr. Chen, she would have conversations with the patient about that, she would try to reduce the medications, she would take efforts to ensure that those two medications, in much as possible, are not overlapping.

She did indicate, though, that sometimes she inherits patients that are taking both. And I

believe in particular, she's not a fan of benzodiazepines, I think she said, for long-term care for anxiety. But sometimes she does have patients that are taking that, she will continue that, but she tries to get those patients on a different medicine.

There is no note in the record that Dr. Okeke had any of those concerns regarding the benzodiazepines. I think -- there's no mention, obviously, the opioids because he didn't do the query, and there's no mention of him wanting to try different medications with her regarding the long-term treatment with benzodiazepines.

The -- again, the medical records have some lack of clarity with regard to the medications she was taking. A provider taking over her care could query her PMP to see what's actually being filled. But with regard to other medications, they would have to rely on her memory to know what medications she was taking because the records are not clear in that regard.

Dr. Chen noted concerns regarding copy and pasting progress notes from visit to visit without significant changes or maybe even any changes in some situations, which she believes lead to a

failure to maintain clear, legible, accurate, and complete medical records. She said even if a patient is stable, she would still have some changes for that patient, usually, because they will be talking about different stressors or different things going on in their life. Even if the medications and other things don't change, visit to visit, what is going on in a patient's life, there's often something new that could be included in the medical record.

So based on that, we believe that we've proven that Dr. Okeke's care of Patient A showed a lack of diligence in both documentation, review and management of her medications, and that fell below the standard of care. The level of standard of care with regard to documentation, medicine choice, and then the fact that he did not query the PMP.

He did give her, in at least one instance, more than a 30-day supply, and I believe the reason for that was the police report wherein she indicated her medication was stolen. But that was another concern that Dr. Chen noted was that there's -- I think it was April of 2019, there's April and then May and then May, so in that time period, she got an extra set of medications.

With regard Patient B, there is a prescription in the record in Exhibit 12, that is a prescription that was given to Patient B. It is dated November 8, 2019, and we did agree on the record that Dr. Okeke left the country at 11:45 p.m. that day. It is possible that he worked that day.

But what is concerning to the Investigative Committee is there is no medical record for Patient B that Dr. Okeke prepared for Patient B on that day. In other words, he would have given him a prescription without seeing him, perhaps, or without making a medical record. And, in fact, I think his response to the Board initially in this case is the most accurate with regard to Patient B, except for the last part. On NSBME 0011, he says, "I saw this patient on October 10, 2019. And he saw another provider in my office November 15, 2019." We have a record for that. We have a record for the October 10th visit, we also have a record for the November 15th visit. And he said, "I gave him a script for the day I saw him," which would have been the October 10th date, "and I did not postdate any script for him." That's the part that we think is inaccurate. We believe that he did postdate the script, and he did not do so correctly,

he did not do so in the manner that the law authorizes.

Dr. Chen explained that today, actually on redirect, what a postdated prescription must include. And it must include three basic elements in addition, obviously, to the medication and signature of the doctor. The first is the date it was actually provided, the second is "do not fill until," and then the date that it should not be filled until.

And so we believe this is an example of a postdated prescription by Dr. Okeke that violates the law.

Dr. Chen noted concerns, if the prescription was provided without a visit, because that could be not maintaining that bona fide patient relationship, and it's not proper to prescribe for a patient when you don't see them. And so that was one concern.

But I think, really, what happened is he provided that prescription on October 10th, that patient saw someone else on November 15th, as the record shows, and he didn't need another prescription on that day because he already had one that was dated for November 8, 2019, that had been

postdated by Dr. Okeke. That would be supported by the patient medical records as well as the PMP and the fill date, and then the paper prescription itself.

We also are concerned regarding Dr. Okeke's failure to query Patient B's patient report from the PMP. That was done in February, 2020. This prescription was November 8, 2019, and we believe that query was done in connection with the Board's letter.

So Dr. Okeke responded March 20, 2020, to the Board's letter regarding Patient B. And the letter regarding Patient B was sent by the Board's investigator February 26, 2020. And part of it, I will admit, is cut off. I think if you look at the other exhibit, the query was actually completed on February 28, 2020, it's just the year that's cut off.

Again, the query was not done in the time period required by law, which would be prior to prescribing the controlled substance and then every 90 days thereafter.

And then Dr. Chen did also talked about, I believe, the Valium being refilled too early from Patient B that he received in April of 2019, two

prescriptions and then one in May.

With regard to patients C, D, and E, I think there's some -- these patients were at a hospital, and so they are not the same, perhaps, as patients that come into Dr. Okeke's office and have regular care with him. However, Dr. Chen still seemed to believe -- and I think today she said that there could still be a query done prior to issuing a controlled substance prescription to those patients. She might cover for someone else, she would look in the file, so it's possible.

And, I guess, this is where, perhaps, we didn't meet our burden. If it's possible that there were a query by another provider that could have been reviewed, but I think Dr. Okeke was out of office, and so he wasn't reviewing that file. His name is still on those prescriptions. Our concern is if someone is putting things in in his name, he has a duty to report to that.

I think he is saying because he was the medical director, he didn't do that. But Dr. Chen, ultimately, ended up saying to us that the query could still have been done and it should have been done if he was doing the prescribing.

So C, D, and E are, again, a little bit

different than A and B, but we would still support the fact that we believe he did not query for those patients, he prescribed to those patients without querying, and that would be a violation of the law.

Based on that, I would ask that the Hearing Officer find that the allegations as contained in Complaint 2, make a recommendation to the Board that those violations have been proven so that the Board may determine the appropriate discipline.

Thank you.

HEARING OFFICER HALSTEAD: Thank you, Ms. Bradley.

Mr. Agwara?

CLOSING STATEMENT

MR. AGWARA: Let me start with the last thing Ms. Bradley said regarding the patients C, D, and E. If I recall correctly, the Hearing Officer specifically asked Dr. Chen for clarification, if he was the medical director and the pharmacist wrote his name down as the prescribing physician, even though he wasn't the attending physician, if that was a problem for Dr. Okeke, and she said no, the pharmacists shouldn't have done that.

So I'll let the record inform the Hearing

Officer.

Regarding -- I mean, this case, let me put it this way because I've been representing Dr. Okeke for a while. At the beginning of this case, I don't know if the Hearing Officer recalls, I stated that this is part of a problem that existed during a period of time when the respondent had to separate his practice from his ex-wife, they were going through a nasty divorce, things were happening, documentation and recordkeeping were a problem.

We had a previous case. I guess also it was Ms. Bradley that represented the IC, where this same issues were dealt with, and the Board refused to find malpractice. But they found deficiencies in recordkeeping, and I'm not sure if they also found failure to run queries. But the failure, we've already admitted that in a previous case. That's -- it was the same time period.

Luckily, that has changed now. I don't think you can even prescribe without the system forcing you to look at the -- if they are integrated, it pops up, all the history.

So -- but we need to keep in mind that we're dealing with six, seven years ago when the rules were just changing, and practitioners, some

were slow to catch up with the rules. That doesn't mean that they were endangering patients.

Now, other than PMP, the rest of this stuff is, you know, preference. You can get five doctors in the room and they will prescribe different things for the same ailment. Dr. Chen has her own preferences.

As the Hearing Officer will recall, we've had multiple practitioners who didn't think it was a problem prescribing benzos while the patient was on opioids, providing the patient full instructions on how to take them.

Now, of course, we have providers like Dr. Chen, who are not comfortable providing or prescribing benzos when a patient is taking opioids. Okay? Does that make one right and the other wrong? No. Multiple times I asked her, show me where it's written that this is the best way to practice this particular medicine. She doesn't -- nobody can show you that.

My client has been practicing psychiatry for almost 30 years. Never had one overdose, never had a patient die because of anything he did or prescribed. So we're talking -- I mean, this -- I wish I could get you the previous, this is exactly

what we dealt with this before. Just because this case was filed separately, it all deals with the same period.

The Board looked at it, said, hey, we think you have a problem with your documentation and your recordkeeping. Yeah, you need to run PMPs, you must run them.

We will give you those two, but these other things about, well, he prescribed this, he should have known better in medicine.

When there are no adverse affects, you will find ten doctors that will all have ten ways of doing the same thing. That's not falling below the standard of care.

So the particular patient who get two prescriptions in one month, if you recall, she went to the police station, filled out a police report saying she lost her medications. And I believe I asked Dr. Chen specifically if that was the proper way to do it. She said "Yes." And in that case, it's not a problem giving a second prescription within the 30 days, so that's not practicing below the standard.

I don't know -- you have the testimony -- we're relying on the Board's own expert and many of

what she stated. However, a lot of it is just preference, how she's comfortable practicing medicine.

The respondent has his own comfortable way of practicing medicine. And they see these patients every month. They are looking at them, interacting with them. Unfortunately, not everything the patient says makes it into records. And sometimes the reasons for upping the dosage or lowering the dosage may not end up in the record. Does that mean that it's below the standard? No. What it means is that, yeah, you need to do a better job of recording your reasons. Does that mean he didn't have a reason to do it? No. He had a reason, based on whatever the patient was complaining about.

So it's -- they use below the standard, the term has been thrown around so much in these hearings that one would think that as soon as another doctor disagrees with you, then what you're doing is below as the standard. All it is is a difference, a preference in practicing medicine. It is not below the standard.

There are, of course, if you don't not run the PMP as required by law because that's a requirement. There's no requirement that says don't

give benzo if the person is taking opioids. No. So what you're going to get there is ten doctors doing ten different things.

We've spent four days going over these things when, to me, the issues, where I think the respondent has some issues, we could have resolved in half a day. Other than this patient here, he didn't do this, would you have done it differently, yes. Okay? If that were the basis, 95 percent of doctors would be practicing below the standard.

We ask that you find that his practice, with exceptions of the two areas that I've mentioned in terms of the PMP, he has -- yeah, there maybe some documentation issues and recordkeeping, but you will find that with every single practitioner out there who has a busy practice. If you find one, look at their records, you will find some deficiencies. Does that mean they are practicing below the standard? No.

So with that, we will submit the case.

HEARING OFFICER HALSTEAD: Thank you, Mr. Agwara.

That concludes all the matters that are currently pending in font of me for Dr. Okeke; correct?

MR. AGWARA: I think so.

What happened with number 5? Did we dismiss?

MS. BRADLEY: I have not reached out to the Investigative Committee, so, no, it's not dismissed yet. Number five is still pending.

I think we're still on the record this case, though.

HEARING OFFICER HALSTEAD: We are. I just wanted to make sure we concluded everything that is set for hearing during this time frame.

MS. BRADLEY: We have.

HEARING OFFICER HALSTEAD: Okay. With that, I just want to put on the record that the parties have previously stipulated in another matter that I would not be bound by the statutory or administrative time frames to come with the order. But I will do my best to make recommendations before the next Board hearing.

Was there anything else that anyone else wants to place on the record with regard to the cases before we conclude this matter?

MR. AGWARA: Nope.

MS. BRADLEY: I would just say, I mean, we were hoping that they be looked at individually, so

I'm a little bit uncomfortable by some of the statements in Mr. Agwara's closing just now, but I did not want to object because I thought that would be inappropriate.

But I guess I would just ask that you look at them individually, because what was testified in a different case earlier this week, et cetera, isn't relevant to the current matter. The current matter stands on its own.

HEARING OFFICER HALSTEAD: To that end, another thing that we discussed is that I would do one order for all cases that we dealt this week, but I would break the cases out within that order. And everyone's fine with that.

MS. BRADLEY: Yeah.

HEARING OFFICER HALSTEAD: Okay. Anything further?

MR. AGWARA: Nope.

HEARING OFFICER HALSTEAD: I want to thank everyone for the time and attention they put into all these matters. With the different cases, it was a lot to squeeze into one week, logistically, and everyone did a really good job accommodating that and addressing everything and presenting their cases.

I want to thank everyone for all the hard work they have put into. With that, we'll be off the record.

(Off the record at 3:40 p.m.)

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

I, BRANDI ANN VIANNEY SMITH, do hereby certify:

That I was present on October 24, 2024, for the hearing via Zoom, and took stenotype notes of the proceedings entitled herein, and thereafter transcribed the same into typewriting as herein appears.

That the foregoing transcript is a full, true, and correct transcription of my stenotype notes of said proceedings consisting of 41 pages, inclusive.

DATED: At Reno, Nevada, this 13th day of November, 2024.

/s/ Brandi Ann Vianney Smith

_____

BRANDI ANN VIANNEY SMITH

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EXHIBIT 1

EXHIBIT 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS
6010 S. Rainbow Blvd., Bldg. A, Ste. 2
Las Vegas, NV 89118

Rachakonda D. Prabhu, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

November 4, 2019

Matthew Okeke, M.D.
2021 South Jones Blvd.
Las Vegas, NV 89146 [redacted]

RE: BME CASE #: [redacted]
PATIENT: [redacted]

Dear Dr. Okeke:

We have received information and a complaint regarding your medical treatment of the above named patient. The complaint alleges your care and treatment of the patient may have fallen below the standard of care.

It is alleged:

1. You may be failing to follow the model policy on the use of opioid analgesics in the treatment of chronic pain for excessively and inappropriately prescribing controlled substances to the above named patient, who is also receiving controlled substances from other providers.

2. The patient's family has informed you the patient does not take her controlled substance prescriptions as prescribed by you and they are extremely concerned she will end up killing herself by overdosing; however, you and your staff have continued to prescribe controlled substances including, but not limited to, Adderall, Clonazepam and methylphenidate.

3. You are in violation of a State Board of Pharmacy statute, Nevada Revised Statute 639.23507, for failing to obtain and review the patient's PMP report at least every 90 days during the course of treatment.

According to these allegations, you may have violated the Nevada Medical Practice Act, Nevada Revised Statutes, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA).

In order to determine whether or not there has been a violation of the NMPA, **please provide a written response to each allegation noted above, as well as complete health care records for the aforesaid patient. Include copies of any imaging, x-ray or other films that were produced during treatment of this patient.** Please include any further information you believe would be useful for the Board to make a determination in this matter. **Please reply to this request within 21 calendar days.**

Please return the health care records with the signed Custodian of Records Affidavit, enclosed herewith. If you are not a custodian of the patient records, please indicate where the health care records can be obtained.

12/3/19

The Nevada State Board of Medical Examiners investigates all information received concerning possible violations of the NMPA. We make no determination as to whether or not there has been a violation of the NMPA until a thorough investigation is completed. As a physician under investigation by the Board, you are required by the NMPA to provide the requested information, and your cooperation is not subject to the whistle-blower protections provided to physicians in NRS 630.364(3).

Please be advised that if the particular allegations referenced above did occur, and depending on the facts and circumstances, then you may have violated the NMPA, specifically including but not limited to: NRS 630.301(4), NAC 630.040, NRS 630.306(1)(b)(3), (1)(c), NAC 630.187, NAC 630.230(1)(k), NRS 639.23507.

Respectfully,

Kim Friedman, CMBI
Sr. Investigator
Las Vegas Office

The Investigative Committee of the Board of Medical Examiners of the State of Nevada

* * * * *

In the Matter of the Investigation of:

Matthew Okeke, M.D.

License No. 14957

Case No. [redacted]

ORDER TO PRODUCE HEALTH CARE RECORDS

The Investigative Committee (IC) of the Board of Medical Examiners of the State of Nevada sends greetings to:

Matthew Okeke, M.D.
2021 S. Jones Blvd.
Las Vegas, NV 89146

Pursuant to the authority of Nevada Revised Statute (NRS) 630.311(1), the IC directs you to produce and deliver to the Nevada State Board of Medical Examiners, the materials as set forth in this Order:

1. Properly authenticated and complete copies of any and all health care records of [redacted].
2. The name and contact information for any entity, facility, or person that you believe may possess the health care records of [redacted]

Said records shall be provided to an investigator of the Nevada State Board of Medical Examiners **within 21 days of service** of this Order (Investigation Division, Attn. Kim Friedman, Sr. Investigator, Nevada State Board of Medical Examiners, 6010 S. Rainbow Blvd., Bld. A, Suite 2 Las Vegas, NV 89118). Failure to comply and produce said records in the aforesaid manner may subject you to potential disciplinary action, to include a violation of NRS 630.3065(2)(a) and NRS 630.3062(4); further, the Investigative Committee may seek administrative sanctions as set forth in NRS 630.352.

Additionally, compliance with this order is deemed compulsory and shall not be deemed to be cooperation subject to the protections provided to a physician pursuant to NRS 630.364(3).

Dated this 4th day of November, 2019.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
INVESTIGATIVE COMMITTEE

M. Neil Duxbury

M. Neil Duxbury, Chairman
Nevada State Board of Medical Examiners
Investigative Committee

EXHIBIT 2

EXHIBIT 2

NEVADA STATE BOARD OF MEDICAL EXAMINERS
6010 S. Rainbow Blvd., Bldg. A, Ste. 2
Las Vegas, NV 89118

Rachakonda D. Prabhu, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

February 26, 2020

Matthew Okeke, M.D.
2021 South Jones Blvd.
Las Vegas, NV 89146

RE: BME CASE #:

Dear Dr. Okeke:

Thank you for your timely response dated November 7, 2019. The Nevada State Board of Medical Examiners is requesting additional information.

Please provide a response to the following questions:

1. Per your response to the Nevada State Board of Medical Examiners you stated you traveled outside the United States, returning on December 8, 2019.
   a. On November 8, 2019, you traveled outside the United States to Murtala Muhammed, however; you pre-signed a prescription for patient , for Suboxone on November 8, 2019. Please provide a detailed explanation of your care and treatment of the patient and why a prescription for a controlled substance with your signature was provided to the patient while you were not in the United States.

2. On November 27, 2019, a prescription for clonazepam, , was received by Well Care Discount Pharmacy located at 3300 W. Charleston Blvd., Ste. B Las Vegas, NV 89102 for patient . The prescription contained your name and DEA number; however, you were outside the United States when you traveled on November 8, 2019, to Murtala Muhammed.
   a. Please provide a detailed explanation of your care and treatment of the patient.
   b. Please provide a detailed explanation as to why you authorized a prescription for a controlled substance to be written with your name and DEA number even though you were outside the United States and did not examine the patient on November 27, 2019.

3. On November 15, 2019, a prescription for Ativan, , was received by Well Care Discount Pharmacy located at 3300 W. Charleston Blvd., Ste. B Las Vegas, NV 89102 for patient . The prescription contained your name and DEA number; however, you were outside the United States when you traveled on November 8, 2019 to Murtala Muhammed.
   a. Please provide a detailed explanation of your care and treatment of the patient.

b. Please provide a detailed explanation as to why you authorized a prescription for a controlled substance to be written with your name and DEA number even though you were outside the United States and did not examine the patient on November 15, 2019.

c. Please provide a detailed explanation as to why you authorized Victor Bruce, M.D. to write the prescription for the controlled substance even though Dr. Bruce does not have a DEA number, or a controlled substance license with the Nevada State Board of Pharmacy; Dr. Bruce's name was listed on the prescription along with your name and DEA number.

4. On November 15, 2019, a prescription for Klonopin, [redacted], was received by Well Care Discount Pharmacy located at 3300 W. Charleston Blvd., Ste. B Las Vegas, NV 89102 for patient [redacted]. The prescription contained your name and DEA number; however, you were outside the United States when you traveled on November 8, 2019 to Murtala Muhammed.

   a. Please provide a detailed explanation of your care and treatment of the patient.

   b. Please provide a detailed explanation as to why you authorized a prescription for a controlled substance to be written with your name and DEA number even though you were outside the United States and did not examine the patient on November 15, 2019.

   c. Please provide a detailed explanation as to why you authorized Victor Bruce, M.D. to write the prescription for the controlled substance even though Dr. Bruce does not have a DEA number, or a controlled substance license with the Nevada State Board of Pharmacy; Dr. Bruce's name was listed on the prescription along with your name and DEA number.

5. On November 27, 2019, a prescription for Suboxone, [redacted], was received by Well Care Discount Pharmacy located at 3300 W. Charleston Blvd., Ste. B Las Vegas, NV 89102 for patient [redacted]. The prescription contained your name and DEA number; however, you were outside the United States when you traveled on November 8, 2019, to Murtala Muhammed.

   a. Please provide a detailed explanation of your care and treatment of the patient.

   b. Please provide a detailed explanation as to why you authorized a prescription for a controlled substance to be written with your name and DEA number even though you were outside the United States and did not examine the patient on November 27, 2019.

In addition please provide a detailed response to the following questions:

1. Please provide the specific date Dr. Victor Bruce was no longer employed by Brightstar Urgent Care and the specific date Dr. Bruce began working at Grand Desert Psychiatry located at 2021 S. Jones Blvd. Las Vegas, NV 89146.

2. Please provide a detailed explanation as to Dr. Bruce's current employment status with Brightstar Urgent Care, Grand Desert Psychiatry and/or any additional entities owned by you or you are the medical director of.

3. Please provide a detailed explanation as to why Dr. Bruce informed the Nevada State Board of Medical Examiners he was no longer employed with Brightstar Urgent Care effective July17, 2019, however; Dr. Bruce is providing treatment, as well as writing prescriptions, to your patients.

4. Please provide a detailed explanation as to how Dr. Victor Bruce is being compensated for his employment with you.

In order to determine whether or not there has been a violation of the Medical Practice Act, **please respond to the request noted above and any information that would be helpful.** Please include any further information you believe would be useful for the Board to make a determination in this matter. **Please reply to this request within 15 days.**

The Nevada State Board of Medical Examiners investigates all information received concerning possible violations of the Nevada Revised Statutes, Chapter 630. We make no determination as to whether or not there has been a violation of the Medical Practice Act, prior to the completion of our investigation. Providing the requested information is deemed a professional obligation of any physician under investigation by the Board and shall not be deemed to be cooperation subject to the whistle-blower protections provided to physicians in NRS 630.364 (3).

Respectfully,

Kim Friedman, CMBI
Sr. Investigator
Las Vegas Office

The Investigative Committee of the Board of Medical Examiners of the State of Nevada

* * * * *

In the Matter of the Investigation of:	
Matthew Okeke, M.D.	Case No. [redacted]
License No. 14957	

ORDER TO PRODUCE HEALTH CARE RECORDS

The Investigative Committee (IC) of the Board of Medical Examiners of the State of Nevada sends greetings to:

Matthew Okeke, M.D.
2021 S. Jones Blvd.
Las Vegas, NV 89146

Pursuant to the authority of Nevada Revised Statute (NRS) 630.311(1), the IC directs you to produce and deliver to the Nevada State Board of Medical Examiners, the materials as set forth in this Order:

1. Properly authenticated and complete copies of any and all health care records, to include billing records, of [redacted].
2. Properly authenticated and complete copies of any and all health care records, to include billing records, of [redacted].
3. Properly authenticated and complete copies of any and all health care records, to include billing records, of [redacted].
4. Properly authenticated and complete copies of any and all health care records, to include billing records, of [redacted].
5. Properly authenticated and complete copies of any and all health care records, to include billing records, of [redacted].

Said records shall be provided to an investigator of the Nevada State Board of Medical Examiners **within 10 days of service** of this Order (Investigation Division, Attn. Kim Friedman, Sr. Investigator, Nevada State Board of Medical Examiners, 6010 S. Rainbow Blvd., Bld. A, Suite 2 Las Vegas, NV 89118). Failure to comply and produce said records in the aforesaid manner may subject you to potential disciplinary action, to include a violation of NRS 630.3065(2)(a) and NRS 630.3062(4); further, the Investigative Committee may seek administrative sanctions as set forth in NRS 630.352.

Additionally, compliance with this order is deemed compulsory and shall not be deemed to be cooperation subject to the protections provided to a physician pursuant to NRS 630.364(3).

Dated this 26th day of February, 2020.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
INVESTIGATIVE COMMITTEE

M. Neil Duxbury

M. Neil Duxbury, Chairman
Nevada State Board of Medical Examiners
Investigative Committee

EXHIBIT 3

EXHIBIT 3

Grand Desert Psychiatric Services

Experience the Difference

11-7-19

[redacted]

RE: BME CASE # [redacted]
PATIENT: [redacted]

Kim Friedman CMBI

1) I did not prescribe any opiates for this patient since 9-25-13.

2) Family members interpretations were not reliable. I did not have the patient's permission to talk to the family members. I did not use any information they provided because of HIPPA Violation as the patient did not consent to family members being involved in her treatment. The patient has been on the same dose of medication since 2014. There have been minor adjustments but no excessive amount was given to the patient. She stayed below the maximum recommended. She got early refills when she produced a police report of medications being stolen.

3) I check the PMP regularly.

I will be out of the country until December 8th 2019.

If you have any further questions please feel free to contact my office at anytime.

Sincerely,

Matthew Okeke M.D.

Matthew Okeke, MD
2021 S Jones Blvd Las Vegas NV, 89146
Phone: 702-202-0099 Fax: 702-778-7632

EXHIBIT 4

EXHIBIT 4

MATTHEW OKEKE, MD, LTD

DBA GRAND DESERT PSYCHIATRIC SERVICES

Experience The Difference

Nevada State Board of Medical Examiners
6010 S. Rainbow Blvd, Bldg A Suite 2
Las Vegas NV [redacted]8

RECEIVED
MAR 11 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS

RE: BME Case [redacted]

1. [redacted]
   I saw this patient 10/10/2019 and he saw another provider in my office 11/15/2019. I gave him a script for the date I saw him and I did not post date any script for him.

2. [redacted]
   I have never seen this patient in any setting that I can remember. I did not give him any prescription. I do not have any record of seeing him or treating him

3. [redacted]
   Patient was in a hospital, Sana Behavioral hospital. I was the medical director and I had a coverage when I traveled and I would guess that they used my name to fill a prescription. I did not authorize the prescription in any way. The medical records are with the hospital
   I have never authorized Dr. Victor Bruce to write any prescription to any patient. We discussed the scope of his license and he understands his limitations. He has never brought a patient to me to write a controlled substance for.

4. [redacted]
   Patient was in a hospital, Sana Behavioral hospital. I was the medical director and I had a coverage when I traveled and I would guess that they used my name to fill a prescription. I did not authorize the prescription in any way. The medical records are with the hospital

5. [redacted]
   Patient was in a hospital, Sana Behavioral hospital. I was the medical director and I had a coverage when I traveled and I would guess that they used my name to fill a prescription. I did not authorize the prescription in any way. The medical records are with the hospital

Additional questions

1. Dr. Bruce started working at Brightstar Urgent care 10/1/2019 and his last day at work was 7/15/2019. I have already provided you with his employment details with Brightstar Urgent Care.

2021 S Jones Blvd Las Vegas NV, 89146 Matthew Okeke MD
PH 702 202 0099 Fax: 702 778 7632 Board Certified Psychiatrist

2. He is no longer working for Brightstar Urgent Care. He did not work for any other entity that I have. He did not work for Grand Desert Psychiatric Services.
3. I was not aware that he was prescribing or treating patients after he stopped working for Brightstar Urgent Care.
4. He was paid for the services he provided as per his contract with Brightstar Urgent Care. He was given a check every month.

Matthew Okeke MD

2021 S Jones Blvd Las Vegas NV, 89146
PH 702 202 0099 Fax: 702 778 7632
Matthew Okeke MD
Board Certified Psychiatrist

EXHIBIT 5

EXHIBIT 5

Before the Board of Medical Examiners of the State of Nevada
Investigative Committee

* * * * *

In the Matter of the Investigation of:	)	
	)	
	)	**Case Nos.** [redacted]
Matthew Obim Okeke, M.D.	)	
	)	
	)	
License #: 14957	)	
	)	

SUBPOENA DUCES TECUM

The Investigative Committee of the Board of Medical Examiners of the State of Nevada sends greetings to:

Delta Air Lines, Inc.
ATTN: Custodian of Records / ROI
1040 Delta Boulevard
Atlanta, GA 30354

Pursuant to the authority of NRS 630.140(1), **WE COMMAND YOU,** that all singular, business and excuses being set aside; you shall produce and deliver to the Nevada State Board of Medical Examiners, the materials as set forth in this Subpoena Duces Tecum:

1. Complete copies of any and all flight records, inbound and outbound, from November 1, 2019 to December 31, 2019, of the following physician/customer:

   Name: Matthew Obin Okeke, MD

   DOB: 03/29/1964

   Business Address: 2021 S. Jones Blvd., Las Vegas, NV 89146

Said records and identification of said individuals shall be forwarded to the Investigation Division, Nevada State Board of Medical Examiners, (Investigation Division, Attn. Monica C. Gustafson, Senior Investigator, Nevada State Board of Medical Examiners, 9600 Gateway Dr., Reno, Nevada 89521), **immediately upon presentation of this subpoena.** Failure to comply and produce said records at the aforesaid time and place may cause the Investigative Committee may seek relief as provided in NRS 630.140(3).

Additionally, compliance with this order is deemed compulsory and shall not be deemed to be cooperation subject to the protections provided to NRS 630.364(3).

Dated this **21st** day of **June** 2024.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
INVESTIGATIVE COMMITTEE

Bret W. Frey, Chairman
Nevada State Board of Medical Examiners
Investigative Committee

Pax Lst Nm	Pax Frst Nm	Date of Birth	Elcr Adr	Ph Nb	Skymiles Acct Nbr	Tot Tkt Amt	Credit Card #	CC Code	Pnr Create Dt	Pnr Recloc	Pnr Recloc1	Tkt Nbr	Tkt Nbr1	Tkt Cpn Stt	DprtDt	Mkd Crr Cd	Mds Flt Nbr	Cpn Orig	Cpn Dest
OKEKE MD	MATTHEW		[redacted]	[redacted]	-	1206.6					09/15/2019	0062176847269	1	Exchanged	11/07/2019	DL	630	LAS	JFK
OKEKE MD	MATTHEW		[redacted]	[redacted]	-	1356.6	[redacted]			GC2FPR	09/26/2019	0062177930856	1	Flown	11/07/2019	DL	1057	LAS	JFK
OKEKE MD	MATTHEW	[redacted]	[redacted]	[redacted]	-	1206.6	[redacted]		09/14/2019	GC2FPR	09/14/2019	0062388530917	1	Exchanged	11/07/2019	DL	630	LAS	JFK
OKEKE MD	MATTHEW	[redacted]	[redacted]		[redacted]	3408.03	[redacted]		09/24/2019	GA9CP9	09/24/2019	0062389177919	1	Flown	11/08/2019	DL	214	JFK	LOS
OKEKE MD	MATTHEW	[redacted]	[redacted]		[redacted]	3408.03	[redacted]		09/24/2019	GA9CP9	09/24/2019	0062389177919	2	Flown	12/05/2019	DL	215	LOS	JFK
OKEKE MD	MATTHEW		[redacted]	[redacted]	-	1206.6					09/15/2019	0062176847269	2	Exchanged	12/06/2019	DL	2371	JFK	LAS
OKEKE MD	MATTHEW		[redacted]	[redacted]	-	1356.6	[redacted]			GC2FPR	09/26/2019	0062177930856	2	Flown	12/06/2019	DL	2371	JFK	LAS
OKEKE MD	MATTHEW	[redacted]	[redacted]	[redacted]	-	1206.6	[redacted]		09/14/2019	GC2FPR	09/14/2019	0062388530917	2	Exchanged	12/06/2019	DL	2371	JFK	LAS

DELTA

SPIL | Imaging | Seat Maps | Logo

historical PNR inquiry

Welcome, Andre Leco

DEFAULT LOOKUP | PASSENGER LOOKUP | FLIGHT NUMBER LOOKUP | ORIGIN-DESTINATION LOOKUP

PNR Locator GC2FPR Ticket No

Employee No. DL PPRID (i.e. 012345600) or PMNW ID (i.e. 123456)

Frequent Flyer No. (i.e. DL1234567890)

Go Clear

* Please enter data in one field per search only

DL PNR Codes NW PNR Codes

DL PNR's from 03/09/2011 to current (prior to 03/09/2011 PNRPUL) NW PNR's Thru 01/30/2010

Print PNR Detail Redisplay List

PNR Detail

```
DL RLOC            GC2FPR
CREATION DATA:       21:53 Z   DATE  14 SEP 2019     DUTY CODE  GS     SIGNATURE  WW     CITY  LAX
                  AGENT SET: 24D63A   SECURITY ID: D006217
THIS PNR WAS ORIGINATED BY AGENT-SET
                  01OKEKEMD/MATTHEW
TICKET/INVOICE NUMBER DATA
                                      0062177930855      26SEP19 E
       OKEKEMD/MATTHEW                0062177930856      26SEP19
TICKETING:  TK/TE/0320A/26SEP
TKI DATA                           E/ -ANON-REF/NON-END - PENALTY APPLIES
FARE                              4P  A-USD  1235.35 TX 121.25          TTL   1356.60 LG26SEP
FARE CALC                          A LAS DL NYC589.77BA7KA0FQ DL LAS645.58KA7KA0DQ USD1235.35E
                                     ND ZP LASJFK XF LAS4.5JFK4.5
FOP REMARKS   1 FOR   1 PSGRS /FOPA/CVI44006H01D8EO5109/06-20/-CID//USD139.54
FOP REMARKS   2 FOR   1 PSGRS /FOPA/CVI44006H01D8EO5109/06-20/-CID//USD139.54
FOP REMARKS   3 FOR   1 PSGRS AP/*04358D/USD350.00/0320A 26SEP19
FOP REMARKS   4 FOR   1 PSGRS AP/*04358D/USD350.00/0320A 26SEP19
                                NMNBR NMRMK                          NAME W/BLANKS
NAME REMARK FOP-  1 AP-  3         1.01
NAME REMARK FOP-  2 AP-  4         2.01                              OKEKE MD/MATTHEW
REMARKS
    -DVDN-4260116 / 0720Z26SEP19
    -EFEE-EBC/0068224583393/USD250.00/LASJFK*
    -IPAP-68.96.254.251*PDWDC** / 2153Z14SEP
    /IBM MAIL TO
    /
SPCL RMKS DATA
    PAX REQUEST TO REMOVE THE RB FROM HIS NAME
    PLZ ASSIST WITH REISSUING
    -15SEP19/Z/RA/GS/VJE -AXIS
FACTS
    OSI TYPE AA
    OSI DL OCI/06NOV/LAS/1753/ATTEMPTED CHECK-IN TOO EARLY
    OSI DL OCI/07NOV/LAS/1702/EBP SENT PAX 9971441633755-02.01
    OSI DL OCI/07NOV/LAS/1702/EBPU 17756226974
ITINERARY:        CARRIER  FLT #  CLASS   FLT DATE    ORG  DST  STATUS  NBR  DPT TIME    ARR TIME    RD
                    DL     1057     C   07 NOV 2019   LAS  JFK   NN/HK   02  11:00 PM     6:46 AM+1  RD
                    SEAT   1057         07 NOV 2019   LAS  JFK   CI/ON   3D   OKEKEMD/MATTHEW
                    DL     2371     I   06 DEC 2019   JFK  LAS   NN/HK   02   8:05 AM    11:16 AM    RD
                    SEAT   2371         06 DEC 2019   JFK  LAS   CI/ON   2D   OKEKEMD/MATTHEW

HISTORY
    AG  OSI TYPE GA
    AT  TE/1200N/14SEP
    AS  DL      630     Z   07 NOV 2019   LAS  JFK   NN/SS   02   6:00 AM     1:58 PM    RD
                                          DL 630 07NOV LASJFK
              /RS  3A  OKEKEMD/MATTHEW
    AS  DL     2371     I   06 DEC 2019   JFK  LAS   NN/SS   02   8:05 AM    11:16 AM    RD
                                          DL2371 06DEC JFKLAS
              /RS  2D  OKEKEMD/MATTHEW
    AV  00001 LASJFK LASJFK 0224 0268  LASJFK 0224 **          00403      0044 Z
    AV  00002 JFKLAS JFKLAS 0113 -9886 JFKLAS 0113 **          00447      0322 Z
    A$  4P  A-USD  1095.81 TX 110.79          TTL   1206.60 WW14SEP
    AC   A LAS DL NYC450.23TAVKA0FQ DL LAS645.58KA7KA0DQ USD1095.81END ZP LASJFK XF LAS4.5JFK4.5
    AT  E/NONREF/PENALTY APPLIES
    PS  LAX  DL A         LAX      GS WW LAXUSLAX  DL  LAS  US S
    AF  DOCS*OKEKEMD/MATTHEW*/////      /M//OKEKE/MATTHEW
14 SEP 2019  2153 Z     D006217    24D63A LAXGSWWLAS  US
    XT  TKTD-TE/1200N/14SEP
    AT  TK/TE/0253P/14SEP
    TI  0062388530917   &YEOKEKEMD/MATTHEW
```

```
  14 SEP 2019  2153 Z     D006217    24D63A LAXGSWW
      QP  QR-XOC/004
  14 SEP 2019  2222 Z     D010662    05ED34 ATLGSAX
[redacted]
      XP  FOPVI44006H01D8EO5109/06-20/-CID/-V0024696077**01.01/02.01
      AP  /*02743D/USD1206.60/0253P 14SEP19/V-3S066 **01.01
      AP  /*02743D/USD1206.60/0253P 14SEP19/V-3S066**02.01
      |
[redacted]
      AG  OSI TYPE AA
[redacted]                                        DL 630 07NOV LASJFK
                                                  DL2371 06DEC JFKLAS
[redacted]
  15 SEP 2019  0552 Z     2553056    1D8929 VJEGSRA
[redacted]
  15 SEP 2019  0553 Z     2553056    1D8929 VJEGSRA
      XT  TKT-TK/TE/0253P/14SEP
      AE  /TBM MAIL TO
[redacted]
      AG  OSI TYPE AA
      AT  TE/1200N/15SEP
      A$  4P  A-USD  1095.81 TX 110.79          TTL   1206.60 RA15SEP
      AC   A LAS DL NYC450.23TAVKA0FQ DL LAS645.58KA7KA0DQ USD1095.81END ZP LASJFK XF LAS4.5JFK4.5
      XD  E/A-*NONREF/PENALTY APPLIES
  15 SEP 2019  0553 Z     2553056    1D8929 VJEGSRA
      XT  TKTD-TE/1200N/15SEP
      AT  TK/TE/0153A/15SEP
      SR  SPCL-DTC APPLIES
[redacted]
      TI  0062176847269   &ZEOKEKEMD/MATTHEW
      TX  TKT NBR 0062388530917    14SEP19 E OKEKEMD/MATTHEW
  15 SEP 2019  0553 Z     2553056    1D8929 VJEGSRA
[redacted]
  15 SEP 2019  0555 Z     2553056    1D8929 VJEGSRA
      QP  QR-XOC/004
  15 SEP 2019  0624 Z     D010662    05ED1A ATLGSAX
      XS  DL      630     Z   07 NOV 2019   LAS  JFK   NN/HK   02   6:00 AM     1:58 PM    RD
[redacted]                                        DL 630 07NOV LASJFK
            RS/XR  3A  OKEKEMD/MATTHEW
      XT  TKT-TK/TE/0153A/15SEP
      AE  /TBM MAIL TO
[redacted]
      AE  /P.O. BOX 45007
      AE  /ATLANTA GA 30320
      AG  OSI TYPE AA
      AT  TE/1200N/26SEP
      AS  DL     1057     C   07 NOV 2019   LAS  JFK   NN/SS   02  11:00 PM     6:46 AM+1  RD
      AV  00005 LASJFK LASJFK 0348 0476  LASJFK 0348 **          00590      0206 D
      A$  4P  A-USD  1235.35 TX 121.25          TTL   1356.60 LG26SEP
      AC   A LAS DL NYC589.77BA7KA0FQ DL LAS645.58KA7KA0DQ USD1235.35END ZP LASJFK XF LAS4.5JFK4.5
      XD  E/A-*NON-REF/NON-END - PENALTY APPLIES
      PS  VJE  DL A         VJE      GS LG VJEUSVJE  DL  LAS  US S
  26 SEP 2019  0720 Z     757578     1F1A29 VJEGSLGLAS  US
      XT  TKTD-TE/1200N/26SEP
      AT  TK/TE/0320A/26SEP
      SR  SPCL-DTC APPLIES
[redacted]
      TI  0062177930856   &4EOKEKEMD/MATTHEW
      TX  TKT NBR 0062176847269    15SEP19 E OKEKEMD/MATTHEW
  26 SEP 2019  0720 Z     757578     1F1A29 VJEGSLG
[redacted]                                        DL1057 07NOV LASJFK
               /RS  3D  OKEKEMD/MATTHEW
  26 SEP 2019  0720 Z     757578     1F1A29 VJEGSLG
[redacted]
      QP  QR-XOC/004
  26 SEP 2019  0730 Z     D010662    05EE10 ATLGSAX
      AG  OSI DL OCI/06NOV/LAS/1753/ATTEMPTED CHECK-IN TOO EARLY
  07 NOV 2019  0153 Z     D014357    18C126 LASFTWW
[redacted]
      AB  BAG DL1057/07NOV LASJFK JFK PENDING2
[redacted]
      AB  BAG DL1057/07NOV LASJFK JFK NOBAG
  07 NOV 2019  0703 Z     D014357    1D5827 LASFTWW
[redacted]                                        DL1057 07NOV LASJFK
  BP/BCN   FT WW LAS  07NOV0704Z D014357 3D7532
         PSGR OKEKEMD/MATTHEW
      AB  BAG DL1057/07NOV LASJFK JFK PENDING2
         PSGR OKEKEMD/MATTHEW
      AB  BAG DL1057/07NOV LASJFK JFK NOBAG
  08 NOV 2019  0103 Z     D014357    18B737 LASFTWW
      SC  SEAT RS/CV  3D  OKEKEMD/MATTHEW           DL1057 07NOV LASJFK
  BP/BCN   FT WW LAS  08NOV0103Z D014357 3D7534
      AG  OSI DL OCI/07NOV/LAS/1702/EBP SENT PAX 9971441633755-02.01
  08 NOV 2019  0103 Z     D014357    18D120 LASFTWW
      AG  OSI DL OCI/07NOV/LAS/1702/EBPU 17756226974
  08 NOV 2019  0103 Z     D014357    1D2033 LASFTWW
[redacted]
      XB  BAG DL1057/07NOV LASJFK JFK NOBAG
      AB  BAG DL1057/07NOV LASJFK JFK 4006 DL357793/070 LBS
  08 NOV 2019  0516 Z     251862     237936 LASPDMF
[redacted]
      AB  BAG DL1057/07NOV LASJFK JFK 4006 DL369503/070 LBS
```

```
  08 NOV 2019  0517 Z     251862     22E614 LASPDMF
          PSGR OKEKEMD/MATTHEW
       XB  BAG DL1057/07NOV LASJFK JFK NOBAG
       AB  BAG DL1057/07NOV LASJFK JFK 4006 DL369505/069 LBS
  08 NOV 2019  0519 Z     251862     237C29 LASPDMF
          PSGR OKEKEMD/MATTHEW
       AB  BAG DL1057/07NOV LASJFK JFK 4006 DL361973/070 LBS
  08 NOV 2019  0520 Z     251862     234312 LASPDMF
[redacted]
       AB  BAG DL1057/07NOV LASJFK JFK 4006 DL368535-ADL PIECE/070 LBS
  08 NOV 2019  0521 Z     251862     235A1A LASPDMF
[redacted]                                          DL1057 07NOV LASJFK
              CI/CI  3D  OKEKEMD/MATTHEW
  BP/BCN   PD MF LAS  08NOV0522Z 251862 30FC35
       SC  SEAT CI/ON  3D  OKEKEMD/MATTHEW           DL1057 07NOV LASJFK
  A@O LAS PD/MR 08NOV0640Z 020739 37062B
[redacted]                                          DL1057 07NOV LASJFK
  A@O LAS PD/MR 08NOV0640Z 020739 37062B
[redacted]
       AB  BAG DL2371/06DEC JFKLAS LAS 4006 DL165256/069 LBS
       AB  BAG DL2371/06DEC JFKLAS LAS 4006 DL165257/070 LBS
  06 DEC 2019  1101 Z     496398     276C25 JFKPDDB
          PSGR OKEKEMD/MATTHEW
       AB  BAG DL2371/06DEC JFKLAS LAS 4006 DL166192/065 LBS
       AB  BAG DL2371/06DEC JFKLAS LAS 4006 DL166193/031 LBS
  06 DEC 2019  1104 Z     496398     276C25 JFKPDDB
[redacted]                                          DL2371 06DEC JFKLAS
              RS/CI  2D  OKEKEMD/MATTHEW
  BP/BCN   PD DB JFK  06DEC1104Z 496398 276C25
[redacted]                                          DL2371 06DEC JFKLAS
  A@O JFK PD/EK 06DEC1233Z 288406 357129
       SC  SEAT CI/ON  2D  OKEKEMD/MATTHEW           DL2371 06DEC JFKLAS
  A@O JFK PD/EK 06DEC1233Z 288406 357129
```

DL PNR's from 03/09/2011 to current (prior to 03/09/2011 PNRPUL) NW PNR's Thru 01/30/2010 SPIL | Imaging | Seat Maps | Logo

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DELTA

SPIL | Imaging | Seat Maps | Logo

historical PNR inquiry

Welcome, Andre Leco

DEFAULT LOOKUP | PASSENGER LOOKUP | FLIGHT NUMBER LOOKUP | ORIGIN-DESTINATION LOOKUP

PNR Locator GA9CP9 Ticket No

Employee No. DL PPRID (i.e. 012345600) or PMNW ID (i.e. 123456)

Frequent Flyer No. (i.e. DL1234567890)

Go Clear

* Please enter data in one field per search only

DL PNR Codes NW PNR Codes

DL PNR's from 03/09/2011 to current (prior to 03/09/2011 PNRPUL) NW PNR's Thru 01/30/2010

Print PNR Detail Redisplay List

PNR Detail

```
DL RLOC            GA9CP9
CREATION DATA:       19:47 Z   DATE  24 SEP 2019     DUTY CODE  GS     SIGNATURE  WW     CITY  LAX
                 AGENT SET: 24D332   SECURITY ID: D006217
THIS PNR: WAS ORIGINATED BY AGENT-SET
PASSENGER NAMES: 01OKEKEMD/MATTHEW
PHONE:      JFK17756226974
TICKET/INVOICE NUMBER DATA
 1.01 OKEKEMD/MATTHEW           0062389177919      24SEP19 E
TICKETING:  TK/TE/1247P/24SEP
TKI DATA                      E/ -ANONREF/PENALTY APPLIES
FARE                         4P  A-USD  2344.00 TX1064.03          TTL   3408.03 WW24SEP
FARE CALC                     A NYC DL LOS M1172.00ZN1J86D6 DL NYC M1172.00ZN1J86D6 NUC23
                                44.00END ROE1.00 XF JFK4.5
FOP REMARKS   1 FOR   1 PSGRS /FOPVI46358I02PH6H6062/07-23/-CID/-V0026163757
FOP REMARKS   2 FOR   1 PSGRS AP/*184975/USD3408.03/1247P 24SEP19/V-3S066
                              NMNBR NMRMK                        NAME W/BLANKS
NAME REMARK FOP-  1 AP-  2         1.01                          OKEKE MD/MATTHEW
REMARKS
    -IPAP-24.234.95.98*PDWDC** / 1947Z24SEP19
    /TBM MAIL TO
    /MATTHEW OKEKE
    /2021 SOUTH JONES BLVD
    /LAS VEGAS NV 89146
    /TBM BILL TO&
    /MATTHEW OKEKE
    /2021 SOUTH JONES BLVD
    /LAS VEGAS NV 89146
    /
   [redacted]
SPCL RMKS DATA
[redacted]
    ***PASSENGER DECLINED COMFORT PLUS UPGRADE***
    IROP-0214/08NOV19JFKLOS2345/FLT DLYD-0459Z DLN 00001
    TRAVEL DOC VERIFIED NI/21B134/115678/LOS/05DEC/1822Z/C1099263282
 [redacted]
FACTS
    OSI TYPE A
 [redacted]
    SSRPCTCDLHK1*OKEKEMD/MATTHEW*/7- [redacted]
    SSRPCMLDLHK1*214/08NOV-OKEKEMD/MATTHEW*
    OSI DL FF9122617641-OKEKEMD/MATTHEW **FO**
ITINERARY:        CARRIER  FLT #  CLASS   FLT DATE    ORG  DST  STATUS  NBR  DPT TIME    ARR TIME    RD
                    DL      214     Z   08 NOV 2019   JFK  LOS   NN/HK   01  11:45 PM     3:55 PM+1  RD
                    SEAT    214         08 NOV 2019   JFK  LOS   CI/ON   4J   OKEKEMD/MATTHEW
                    DL      215     Z   05 DEC 2019   LOS  JFK   NN/HK   01  11:55 PM     5:55 AM+1  RD
                    SEAT    215         05 DEC 2019   LOS  JFK   CI/ON   3G   OKEKEMD/MATTHEW

HISTORY
    AG  OSI TYPE A
 [redacted]
    AT  TE/1200N/24SEP
    AS  DL      214     Z   08 NOV 2019   JFK  LOS   NN/SS   01  11:45 PM     3:55 PM+1  RD
    AS  SEAT   /RS  4J  OKEKEMD/MATTHEW           DL 214 08NOV JFKLOS
    AS  DL      215     Z   05 DEC 2019   LOS  JFK   NN/SS   01  11:55 PM     5:55 AM+1  RD
    AS  SEAT   /RS  5A  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
    AV  00001 JFKLOS JFKLOS 1194 -8805 JFKLOS 1194 US          01637     -9999 Z
    AV  00002 LOSJFK LOSJFK 0767 -9232 LOSJFK 0767 US          01637     -9999 Z
    A$  4P  A-USD  2344.00 TX1064.03          TTL   3408.03 WW24SEP
    AC   A NYC DL LOS M1172.00ZN1J86D6 DL NYC M1172.00ZN1J86D6 NUC2344.00END ROE1.00 XF JFK4.5
    AT  E/NONREF/PENALTY APPLIES
    PS  LAX  DL A         LAX      GS WW LAXUSLAX  DL  JFK  US S
    AF  DOCS*OKEKEMD/MATTHEW*/// [redacted]
24 SEP 2019  1947 Z     D006217    24D332 LAXGSWWJFK  US
    AG  SSRPCTCDLHK1*OKEKEMD/MATTHEW*/1-OKEKEMD/2-MATTHEW/[redacted]
    AG  SSRPCTCDLHK1*OKEKEMD/MATTHEW*/7-7025159680
[redacted]//OKEKE/MATTHEW
                                          //OKEKE/MATTHEW
24 SEP 2019  1947 Z     D006217    24D332 LAXGSWW
    XT  TKTD-TE/1200N/24SEP
    AT  TK/TE/1247P/24SEP
    TI  0062389177919   &2EOKEKEMD/MATTHEW
24 SEP 2019  1947 Z     D006217    24D332 LAXGSWW
    QP  QR-XNV/004
24 SEP 2019  2025 Z     D010662    05EE16 ATLGSAX
    XS  SEAT RS/NR  5A  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
    AS  SEAT RS/NR  5A  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
```


Okeke Adjudication

312

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SEAT REAC- 05OCT1659Z
    XS  SEAT RS/NR  5A  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
    AS  SEAT   /RS  5A  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
SEAT REAC- 05OCT1659Z
    XS  SEAT RS/NR  5A  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
    AS  SEAT RS/NR  5A  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
SEAT REAC- 12OCT1534Z
    XS  SEAT RS/NR  5A  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
    AS  SEAT   /RS  5A  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
SEAT REAC- 12OCT1534Z
    AM  SSRPCMLDLHK1*214/08NOV-OKEKEMD/MATTHEW*
06 NOV 2019  2045 Z     D027934    3B6E28 ATLGSPM
    AF  DOCS*OKEKEMD/MATTHEW*/P/NGA/A08880339/NGA/29MAR64/M/09JAN23/OKEKE/MATTHEW OBIM/VFY
    AF  DOCA*OKEKEMD/MATTHEW*/R/NGA
09 NOV 2019  0104 Z     277045     276C25 JFKFTSW
        PSGR OKEKEMD/MATTHEW
    AB  BAG DL0214/08NOV JFKLOS LOS 4006 DL453208/070 LBS
    AB  BAG DL0214/08NOV JFKLOS LOS 4006 DL453209/070 LBS
09 NOV 2019  0105 Z     277045     276C25 JFKFTSW
    SR  SPCL-PSGR MUST PRESENT VI***********6062
09 NOV 2019  0105 Z     277045     276C25 JFKFTSW
    SC  SEAT RS/CI  4J  OKEKEMD/MATTHEW           DL 214 08NOV JFKLOS
BP/BCN   FT SW JFK  09NOV0106Z 277045 276C25
    AF  OSI DL FF9122617641-OKEKEMD/MATTHEW **FO**
09 NOV 2019  0149 Z     777313     310C3B JFKPDMP
    SC  SEAT CI/ON  4J  OKEKEMD/MATTHEW           DL 214 08NOV JFKLOS
A@O JFK PD/EC 09NOV0406Z 950141 36EA18
    SC  DL      214     Z   08 NOV 2019   JFK  LOS   NN/HK   01  11:45 PM     3:55 PM+1  RD
IROP-ADD  FT FT OSS 09NOV0459Z
    SC  DL      214     Z   08 NOV 2019   JFK  LOS   NN/HK   01  11:45 PM     3:55 PM+1  RD
IROP-ADD  FT FT OSS 09NOV0508Z
    SC  DL      214     Z   08 NOV 2019   JFK  LOS   NN/HK   01  11:45 PM     3:55 PM+1  RD
IROP-ADD  FT FT OSS 09NOV0528Z
    DS  DOCS*OKEKEMD/MATTHEW*/P/NGA/A08880339/NGA/29MAR64/M/09JAN23/OKEKE/MATTHEW OBIM/VFY
    DS  DOCA*OKEKEMD/MATTHEW*/R/NGA
    AF  DOCS*OKEKEMD/MATTHEW*/P/NGA/A08880339/NGA/29MAR64/M/09JAN23/OKEKE/MATTHEW OBIM/VFY
    AF  DOCA*OKEKEMD/MATTHEW*/R/USA
    AF  DOCS*OKEKEMD/MATTHEW*/C1/USA/099263282/NGA/29MAR64/M/04APR26/OKEKE/MATTHEW OBIM/VFY
    AF  DOCA*OKEKEMD/MATTHEW*/R/USA
05 DEC 2019  1822 Z     115678     21B134 LOSPDNI
    SR  SPCL-TRAVEL DOC VERIFIED SW/276C25/277045/JFK/09NOV/0104Z/PA08880339
    SR  SPCL-VISA RQD Y SW/276C25/277045/JFK/09NOV/0104Z/PA08880339
05 DEC 2019  1822 Z     115678     21B134 LOSPDNI
        PSGR OKEKEMD/MATTHEW
    AB  BAG DL0215/05DEC LOSJFK JFK 4006 DL127073/028 KGS
    AB  BAG DL0215/05DEC LOSJFK JFK 4006 DL127074/013 KGS
05 DEC 2019  1822 Z     494123     21B136 LOSPDDO
    SC  SEAT RS/CI  5A  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
BP/BCN   PD NI LOS  05DEC1823Z 115678 21B134
    XS  SEAT CI/XC  5A  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
    AS  SEAT   /RS  3G  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
05 DEC 2019  1825 Z     115678     21B134 LOSPDNI
    SC  SEAT RS/CI  3G  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
BP/BCN   PD NI LOS  05DEC1825Z 115678 21B134
    SC  SEAT CI/ON  3G  OKEKEMD/MATTHEW           DL 215 05DEC LOSJFK
A@O LOS PD/SH 05DEC2156Z 400516 377B23
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DL PNR's from 03/09/2011 to current (prior to 03/09/2011 PNRPUL) NW PNR's Thru 01/30/2010 SPIL | Imaging | Seat Maps | Logou

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EXHIBIT 6

EXHIBIT 6

Nevada PRESCRIPTION MONITORING PROGRAM

775-687-5694

Report Prepared: 02/13/2024

Prescriber Activity Report

Date Range: 01/01/2019 - 12/31/2019

Investigation Type:
Case Number:
Primary Drug Category:
Drug Product Name:
Case Notes:
Agency:
Contact: Darla Zarley
Role: Admin
Phone: 7756875694
Email: dzarley@pharmacy.nv.gov

MATTHEW OKEKE
2021 S JONES BLVD
LAS VEGAS, NV 89146

Report Criteria

DEA Number: FO4173845, **Prescriber First Name:** MATTHEW, **Prescriber Last Name:** OKEKE

Summary	
Prescriptions	3736
Patients	847
Pharmacies	262

Prescriber Activity

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											
[redacted]			01/06/2020	12/12/2019	SUBOXONE 8 MG-2 MG SL FILM	F1120	60.0	30	TRIN1363	200132	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											
[redacted]			12/12/2019	12/12/2019	DIAZEPAM 5 MG TABLET	F411	60.0	30	TRIN1363	200133	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											
[redacted]			11/27/2019	11/27/2019	BUPRENORP-NALOX 8-2 MG SL FILM		10.0	5	WELL6148	417273	Private Pay
[redacted]			11/27/2019	11/27/2019	CLONAZEPAM 1 MG TABLET		14.0	7	WELL6148	417262	Commercial Insurance
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											
[redacted]			11/15/2019	11/15/2019	CLONAZEPAM 1 MG TABLET		60.0	30	WELL6148	417157	Private Pay
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											
[redacted]			11/08/2019	11/08/2019	SUBOXONE 8 MG-2 MG SL FILM	F1120	60.0	30	TRIN1363	196242	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			10/15/2019	10/10/2019	DIAZEPAM 5 MG TABLET	F411	60.0	30	TRIN1363	193275	Medicaid
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			10/10/2019	10/10/2019	SUBOXONE 8 MG-2 MG SL FILM	F1120	60.0	30	TRIN1363	193276	Medicaid
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[redacted]			09/16/2019	09/09/2019	DIAZEPAM 5 MG TABLET	F411	60.0	30	TRIN1363	190096	Medicaid
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[redacted]			08/27/2019	08/26/2019	SUBOXONE 8 MG-2 MG SL FILM	F1120	30.0	15	TRIN1363	188855	Medicaid
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[redacted]			08/19/2019	08/08/2019	DIAZEPAM 5 MG TABLET	G4700	60.0	30	TRIN1363	187227	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			08/08/2019	08/08/2019	SUBOXONE 8 MG-2 MG SL FILM	F1120	30.0	15	TRIN1363	187226	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
GRANDEL	JENNIFER	05/19/1992	07/25/2019	07/22/2019	CLONAZEPAM 1 MG TABLET	F411	60.0	30	WALG0055	1929739	Commercial Insurance
GRANDEL	JENNIFER	05/19/1992	07/25/2019	07/22/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB	F900	60.0	30	WALG0055	1929738	Commercial Insurance
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											
[redacted]			07/11/2019	04/24/2019	DIAZEPAM 5 MG TABLET	G4700	60.0	30	TRIN1363	178605	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			06/26/2019	06/26/2019	CLONAZEPAM 1 MG TABLET	F411	60.0	30	WALG0055	1917041	Commercial Insurance
			06/26/2019	06/26/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB		60.0	30	WALG0055	1917040	Commercial Insurance
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			06/07/2019	05/09/2019	DIAZEPAM 5 MG TABLET	G4700	60.0	30	TRIN1363	179750	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			05/27/2019	05/20/2019	CLONAZEPAM 0.5 MG TABLET	F411	60.0	30	SMIT4395	4001423	Medicaid
			05/27/2019	05/20/2019	METHYLPHENIDATE 10 MG TABLET	F900	60.0	30	SMIT4395	2001724	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]			05/15/2019	05/09/2019	SUBOXONE 8 MG-2 MG SL FILM	F1120	60.0	30	TRIN1363	179751	Medicaid

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			05/07/2019	04/24/2019	DIAZEPAM 5 MG TABLET	G4700	60.0	30	TRIN1363	178605	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											
[redacted]			05/02/2019	05/02/2019	DEXTROAMP-AMPHETAMIN 20 MG TAB	F900	60.0	30	WALG3085	600800	Commercial Insurance
			05/02/2019	05/02/2019	CLONAZEPAM 0.5 MG TABLET	F411	60.0	30	WALG3085	600799	Commercial Insurance
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			04/22/2019	04/11/2019	DIAZEPAM 5 MG TABLET	G4700	30.0	30	TRIN1363	177707	Medicaid
			04/22/2019	04/11/2019	PHENOBARBITAL 32.4 MG TABLET		60.0	30	TRIN1363	177756	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			04/15/2019	04/11/2019	SUBOXONE 8 MG-2 MG SL FILM	F1120	60.0	30	TRIN1363	177758	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			04/04/2019	04/04/2019	CLONAZEPAM 1 MG TABLET	F411	60.0	30	SMIT4395	4001173	Medicaid
			04/04/2019	04/04/2019	METHYLPHENIDATE 20 MG TABLET	F900	60.0	30	SMIT4395	2001392	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

100 / 140

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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101 / 140

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			03/26/2019	03/14/2019	DIAZEPAM 5 MG TABLET	F411	60.0	30	TRIN1363	175530	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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105 / 140

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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			03/15/2019	03/14/2019	PHENOBARBITAL 32.4 MG TABLET	G4700	60.0	30	TRIN1363	175534	Medicaid
[redacted]											
[redacted]			03/15/2019	03/14/2019	SUBOXONE 8 MG-2 MG SL FILM	F1120	60.0	30	TRIN1363	175525	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

111 / 140

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											
[redacted]			03/05/2019	03/04/2019	CLONAZEPAM 1 MG TABLET	F411	60.0	30	SMIT4395	4001004	Medicaid
[redacted]											
[redacted]			03/05/2019	03/04/2019	METHYLPHENIDATE 20 MG TABLET	F900	60.0	30	SMIT4395	2001162	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			02/21/2019	02/13/2019	DIAZEPAM 5 MG TABLET	F411	60.0	30	TRIN1363	173299	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

127 / 140

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
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[redacted]			02/15/2019	02/13/2019	PHENOBARBITAL 32.4 MG TABLET	F411	60.0	30	TRIN1363	173298	Medicaid
[redacted]											

Last	First	DOB	Fill Date	Written Date	Drug Name	ICD-10	Qty	Supply	Store ID	Rx #	Pymt Type
[redacted]											

Dispensers

Store ID	Name	Address	City	State	Zip
SMIT7605	SMITH'S PHARMACY #311	8050 S RAINBOW BLVD	LAS VEGAS	NV	89139
WARM9454	WARM SPRINGS ROAD CVS, L.L.C.	1990 W SUNSET RD	HENDERSON	NV	89014-2398
SMIT8451	SMITH'S FOOD & DRUG CTRS	4840 W DESERT INN RD	LAS VEGAS	NV	89102-9125

Store ID	Name	Address	City	State	Zip
WAL-2124	WAL-MART PHARMACY 10-3788	6310 W CHARLESTON BLVD	LAS VEGAS	NV	89146-1128
WALG2908	WALGREEN CO.	3717 LAS VEGAS BLVD S	LAS VEGAS	NV	89109
LONG1571	LONGS DRUG STORES CALIFORNIA, L.L.C.	1950 VILLAGE CENTER CIR	LAS VEGAS	NV	89134-6236
WELL6148	WELL CARE APOTHECARY, LLC	3300 W CHARLESTON BLVD	LAS VEGAS	NV	89102-1829
WAL-8655	WAL-MART PHARMACY 10-3351	6464 N DECATUR BLVD	LAS VEGAS	NV	89131-2959
SMIT9317	SMITH'S FOOD KING NO 1	850 S RANCHO DR	LAS VEGAS	NV	89106-3810
NEVA4719	NEVADA CVS PHARMACY, L.L.C.	2830 BICENTENNIAL PKWY	HENDERSON	NV	89044-4476
THE 5724	THE VONS COMPANIES INC	475 E WINDMILL LN	LAS VEGAS	NV	89123
DIVI2658	DIVINE TOUCH SERVICES, PHARMACY & COMPOU	2208 E CHARLESTON BLVD	LAS VEGAS	NV	89104-2049
WARM4899	WARM SPRINGS ROAD CVS, L.L.C.	3270 S BUFFALO DR	LAS VEGAS	NV	89117-2503
SMIT5183	SMITH'S PHARMACY #361	4700 W ANN RD	NORTH LAS VEGAS	NV	89031-3463
WALG5204	WALGREEN CO.	6865 W TROPICANA AVE	LAS VEGAS	NV	89103-4383
WALG9500	WALGREEN CO.	2389 E WINDMILL LN	LAS VEGAS	NV	89123-2037
WALG0055	WALGREEN CO.	7755 N DURANGO DR	LAS VEGAS	NV	89131-8190
WALG1440	WALGREEN CO.	5011 E SAHARA AVE	LAS VEGAS	NV	89142-2911
REAL2807	REAL CARE PHARMACY	4723 E FLAMINGO RD	LAS VEGAS	NV	89121
WALG8832	WALGREEN CO.	10510 SOUTHERN HIGHLANDS PKWY	LAS VEGAS	NV	89141-4373
NEVA5323	NEVADA CVS PHARMACY, L.L.C.	1360 E FLAMINGO RD	LAS VEGAS	NV	89119-5252
ALBE7338	ALBERTSON'S LLC	8410 FARM RD	LAS VEGAS	NV	89131-8158
WALG4394	WALGREEN CO.	6825 N DURANGO DR	LAS VEGAS	NV	89149-4594
WALG0645	WALGREEN CO.	11001 S EASTERN AVE	HENDERSON	NV	89052-2954
KEN'3026	KEN'S PROFESSIONAL COMPOUNDING PHARMACY	2202 W CHARLESTON BLVD	LAS VEGAS	NV	89102-2229
REFI4386	REFILL PHARMACY 1, LLC	8536 DEL WEBB BLVD	LAS VEGAS	NV	89134
WALG0933	WALGREEN CO.	385 E SILVERADO RANCH BLVD	LAS VEGAS	NV	89183-4428
WALG6230	WALGREEN CO.	9420 W LAKE MEAD BLVD	LAS VEGAS	NV	89134-8312
WALG1165	WALGREEN CO.	3339 LAS VEGAS BLVD S	LAS VEGAS	NV	89109-1401
WALG7522	WALGREEN CO.	4470 E BONANZA RD	LAS VEGAS	NV	89110-6330
ALBE8686	ALBERTSONS LLC	6730 N HUALAPAI WAY	LAS VEGAS	NV	89149
NEVA0398	NEVADA CVS PHARMACY, L.L.C.	2662 W HORIZON RIDGE PKWY	HENDERSON	NV	89052-2844

Store ID	Name	Address	City	State	Zip
WALG7856	WALGREEN CO.	6435 ALIANTE PKWY	NORTH LAS VEGAS	NV	89084-3196
NEVA7524	NEVADA CVS PHARMACY, L.L.C.	10400 W CHARLESTON BLVD	LAS VEGAS	NV	89135-1035
WALG4696	WALGREEN CO.	8595 W WARM SPRINGS RD	LAS VEGAS	NV	89113-3625
WALG4888	WALGREEN CO.	2421 E BONANZA RD	LAS VEGAS	NV	89101-3400
SUN 8822	SUN DRUG INC	2410 E BONANZA RD	LAS VEGAS	NV	89101-3452
WARM7067	WARM SPRINGS ROAD CVS, L.L.C.	4490 PARADISE RD	LAS VEGAS	NV	89169-6573
WAL-7717	WAL-MART PHARMACY 10-2838	540 MARKS ST	HENDERSON	NV	89014-6654
SMIT0889	SMITH'S PHARMACY #370	3160 N RAINBOW BLVD	LAS VEGAS	NV	89108-4533
WAL-4779	WAL-MART PHARMACY 10-3728	3950 W LAKE MEAD BLVD	NORTH LAS VEGAS	NV	89032-4895
OMNI2027	OMNICARE OF NEVADA LLC	1525 E SUNSET RD	LAS VEGAS	NV	89119
NEVA6056	NEVADA CVS PHARMACY, L.L.C.	1812 E CHARLESTON BLVD	LAS VEGAS	NV	89104-1951
SMIT2507	SMITH MANAGEMENT CORP DBA	3850 E FLAMINGO RD	LAS VEGAS	NV	89121-6227
JAY 3425	JAY MATAJI INC	2202 W CHARLESTON BLVD	LAS VEGAS	NV	89102-2229
WARM2001	WARM SPRINGS ROAD CVS, L.L.C.	4001 S MARYLAND PKWY	LAS VEGAS	NV	89119
COST8926	COSTCO WHOLESALE CORPORATION	801 S PAVILION CENTER DR	LAS VEGAS	NV	89144-4566
COST0494	COSTCO WHOLESALE CORPORATION	791 MARKS ST	HENDERSON	NV	89014-8601
WARM0546	WARM SPRINGS ROAD CVS, L.L.C.	2425 E DESERT INN RD	LAS VEGAS	NV	89121-3616
WALG6919	WALGREEN CO.	3186 S MARYLAND PKWY	LAS VEGAS	NV	89109
WARM8662	WARM SPRINGS ROAD CVS, L.L.C.	7285 ALIANTE PKWY	NORTH LAS VEGAS	NV	89084
ALBE7148	ALBERTSON'S LLC	5881 E CHARLESTON BLVD	LAS VEGAS	NV	89142-1010
WALG6065	WALGREEN CO.	6401 W CHARLESTON BLVD	LAS VEGAS	NV	89146
NEVA9755	NEVADA CVS PHARMACY, L.L.C.	2935 S HOLLYWOOD BLVD	LAS VEGAS	NV	89122-3715
WARM0314	WARM SPRINGS ROAD CVS, L.L.C.	1825 E WARM SPRINGS RD	LAS VEGAS	NV	89119-4547
WARM2158	WARM SPRINGS ROAD CVS, L.L.C.	9695 S MARYLAND PKWY	LAS VEGAS	NV	89123-5950
NEVA9554	NEVADA CVS PHARMACY, L.L.C.	8580 W CHARLESTON BLVD	LAS VEGAS	NV	89117-1238
WARM4052	WARM SPRINGS ROAD CVS, L.L.C.	3290 S FORT APACHE RD	LAS VEGAS	NV	89117
NEVA5335	NEVADA CVS PHARMACY, L.L.C.	3550 W SAHARA AVE	LAS VEGAS	NV	89102-5867
WEST5371	WEST VALLEY PHARMACY	6125 W SAHARA AVE	LAS VEGAS	NV	89146-3002
WALG2886	WALGREEN CO.	6820 W ANN RD	LAS VEGAS	NV	89130-1113

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WALG4772	WALGREEN CO.	4930 BLUE DIAMOND RD	LAS VEGAS	NV	89139
WARM2742	WARM SPRINGS ROAD CVS, L.L.C.	6391 W LAKE MEAD BLVD	LAS VEGAS	NV	89108
WARM9274	WARM SPRINGS ROAD CVS, L.L.C.	9405 W RUSSELL RD	LAS VEGAS	NV	89148-5552
WASH0302	WASHINGTON LAMB CVS, L.L.C.	4391 E WASHINGTON AVE	LAS VEGAS	NV	89110
WARM2051	WARM SPRINGS ROAD CVS, L.L.C.	8750 W CHARLESTON BLVD	LAS VEGAS	NV	89117-5452
SMIT9307	SMITH'S PHARMACY	2385 E WINDMILL LN	LAS VEGAS	NV	89123-2037
SMIT7290	SMITH'S PHARMACY #332	7130 N DURANGO DR	LAS VEGAS	NV	89149-4466
WARM2099	WARM SPRINGS ROAD CVS, L.L.C.	4100 BLUE DIAMOND RD	LAS VEGAS	NV	89139-7717
AZ P0035	AZ PHARMACY, LLC DBA PILLPACK PHOENIX	3809 E WATKINS ST	PHOENIX	AZ	85034-7264
PILL3633	PILLPACK, LLC	250 COMMERCIAL ST	MANCHESTER	NH	03101
SMIT0877	SMITH'S PHARMACY #349	10100 W TROPICANA AVE	LAS VEGAS	NV	89147-8459
WARM2087	WARM SPRINGS ROAD CVS, L.L.C.	4155 S GRAND CANYON DR	LAS VEGAS	NV	89147-7123
MESQ4470	MESQUITE PHARMACY AND MEDICAL SUPPLIES	114 N SANDHILL BLVD	MESQUITE	NV	89027-4703
NEVA8549	NEVADA CVS PHARMACY, L.L.C.	2100 W CHARLESTON BLVD	LAS VEGAS	NV	89102-2224
SMIT3875	SMITH'S PHARMACY #338	6855 ALIANTE PKWY	NORTH LAS VEGAS	NV	89084-3195
WALG9636	WALGREEN CO.	3480 S JONES BLVD	LAS VEGAS	NV	89146-6709
COST8404	COSTCO WHOLESALE CORPORATION	3411 SAINT ROSE PKWY	HENDERSON	NV	89052-4570
COMM5949	COMMUNITY CARE PHARMACY	1820 E LAKE MEAD BLVD	N LAS VEGAS	NV	89030-7134
WALG0479	WALGREEN CO.	6485 S FORT APACHE RD	LAS VEGAS	NV	89148-6742
ALBE7302	ALBERTSON'S LLC	7151 W CRAIG RD	LAS VEGAS	NV	89129-6511
MLK 3973	MLK PHARMACY	1100 N MARTIN L KING BLVD	LAS VEGAS	NV	89106-2853
WARM7562	WARM SPRINGS ROAD CVS, L.L.C.	4595 E FLAMINGO RD	LAS VEGAS	NV	89121-4738
WALG8809	WALGREEN CO.	1500 S BOULDER HWY	HENDERSON	NV	89015-8506
WALG1585	WALGREEN CO.	3400 BOULDER HWY	LAS VEGAS	NV	89121-1522
SHRE9049	SHREE SAINATH LLC	4101 WAGON TRAIL AVE	LAS VEGAS	NV	89118-4426
THE 2711	THE VONS COMPANIES INC	45 E HORIZON RIDGE PKWY	HENDERSON	NV	89002
WAL-8961	WAL-MART PHARMACY 10-5259	6151 W LAKE MEAD BLVD	LAS VEGAS	NV	89108-2660
ALBE3900	ALBERTSONS LLC	7975 BLUE DIAMOND RD	LAS VEGAS	NV	89178-9298
SMIT8910	SMITH MANAGEMENT CORP DBA	1255 BARING BLVD	SPARKS	NV	89434-8673

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SMIT1483	SMITH'S PHARMACY #345	5564 CAMINO AL NORTE	NORTH LAS VEGAS	NV	89031
WALG6549	WALGREEN CO.	7599 W LAKE MEAD BLVD	LAS VEGAS	NV	89128-0274
WAL-8243	WAL-MART PHARMACY 10-3655	10440 W CHEYENNE AVE	LAS VEGAS	NV	89129-8712
ACRX3108	ACRX SPECIALTY PHARMACY	3200 SOARING GULLS DR	LAS VEGAS	NV	89129-2198
BARC8458	BARCLAY, LUKE & PILLAI SPECIALTY PHARMAC	8352 W WARM SPRINGS RD	LAS VEGAS	NV	89113-3629
WAL-8922	WAL-MART PHARMACY 10-3473	4505 W CHARLESTON BLVD	LAS VEGAS	NV	89102-1501
WARM3107	WARM SPRINGS ROAD CVS, L.L.C.	3655 W CRAIG RD	NORTH LAS VEGAS	NV	89032
ALBE7186	ALBERTSON'S LLC	7350 S RAINBOW BLVD	LAS VEGAS	NV	89139-0400
NEVA4531	NEVADA CVS PHARMACY, L.L.C.	2855 S NELLIS BLVD	LAS VEGAS	NV	89121-7505
GENO4881	GENOA HEALTHCARE, LLC	1901 S JONES BLVD	LAS VEGAS	NV	89146-1260
SMIT6155	SMITH'S PHARMACY #364	10600 SOUTHERN HIGHLANDS PKWY	LAS VEGAS	NV	89141-4368
SMIT2664	SMITH'S FOOD & DRUG CTRS	1421 N JONES BLVD	LAS VEGAS	NV	89108-1610
NEVA4023	NEVADA CVS PHARMACY, L.L.C.	2525 S BUFFALO DR	LAS VEGAS	NV	89117-2984
WAL-3589	WAL-MART PHARMACY 10-3356	7445 S EASTERN AVE	LAS VEGAS	NV	89123
WAL-0528	WAL-MART PHARMACY 10-1560	6005 S EASTERN AVE	LAS VEGAS	NV	89119-3135
NEVA7072	NEVADA CVS PHARMACY, L.L.C.	3485 E OWENS AVE	NORTH LAS VEGAS	NV	89030-7403
WALG3405	WALGREEN CO.	101 E LAKE MEAD PKWY	HENDERSON	NV	89015-5532
WAL-2447	WAL-MART PHARMACY 10-3354	1401 AMERICAN PACIFIC DR	HENDERSON	NV	89074-7401
WARM4040	WARM SPRINGS ROAD CVS, L.L.C.	7190 W CRAIG RD	LAS VEGAS	NV	89129-6512
WALG1084	WALGREEN CO.	770 S HIGHWAY 160	PAHRUMP	NV	89048
WALG2667	WALGREEN CO.	7845 W FLAMINGO RD	LAS VEGAS	NV	89147-4219
THE 1533	THE VONS COMPANIES INC	8540 W DESERT INN RD	LAS VEGAS	NV	89117-9155
JFGO5606	JFGO HEALTH PHARMACIES	2290 MCDANIEL ST	NORTH LAS VEGAS	NV	89030
WALG2461	WALGREEN CO.	1180 E FLAMINGO RD	LAS VEGAS	NV	89119-3449
WAL-0811	WAL-MART PHARMACY 10-5423	6570 E LAKE MEAD BLVD	LAS VEGAS	NV	89156-7044
ASSI2247	ASSIST CARE PHARMACY INC	3045 E POST RD	LAS VEGAS	NV	89120-2791
ALBE7352	ALBERTSON'S LLC	4055 S DURANGO DR	LAS VEGAS	NV	89147-4158
WALG9277	WALGREEN CO.	1701 N GREEN VALLEY PKWY	HENDERSON	NV	89074-5885
AEVA5932	AEVA LLC	6280 S VALLEY VIEW BLVD	LAS VEGAS	NV	89118-6833

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TANG0713	TANGO, PLLC	4090 W CRAIG RD	NORTH LAS VEGAS	NV	89032-2758
NEVA0386	NEVADA CVS PHARMACY, L.L.C.	7007 W ANN RD	LAS VEGAS	NV	89130
SMIT6685	SMITH'S PHARMACY #304	4001 S DECATUR BLVD	LAS VEGAS	NV	89103-5860
WALG6071	WALGREEN CO.	6001 W CHEYENNE AVE	LAS VEGAS	NV	89108-4205
WALG3647	WALGREEN CO.	8582 BLUE DIAMOND RD	LAS VEGAS	NV	89178-9202
WARM0001	WARM SPRINGS ROAD CVS, L.L.C.	5545 EL CAMINO AL NORTE	NORTH LAS VEGAS	NV	89031
RALE1572	RALEY'S PHARMACY #108	18144 WEDGE PKWY	RENO	NV	89511-8168
LONG1292	LONGS DRUG STORES CALIFORNIA, L.L.C.	8005 S VIRGINIA ST	RENO	NV	89511-8940
NEVA1250	NEVADA CVS PHARMACY, L.L.C.	100 S HIGHWAY 160	PAHRUMP	NV	89048-2130
NEVA3405	NEVADA CVS PHARMACY, L.L.C.	4411 E BONANZA RD	LAS VEGAS	NV	89110-3385
WAL-5078	WAL-MART PHARMACY 10-5070	5200 S FORT APACHE RD	LAS VEGAS	NV	89148-1722
WALG3390	WALGREEN CO.	3150 N TENAYA WAY	LAS VEGAS	NV	89128-0462
WAL-2456	WAL-MART PHARMACY 10-1559	201 N NELLIS BLVD	LAS VEGAS	NV	89110-5321
NEVA4598	NEVADA CVS PHARMACY, L.L.C.	2594 WIGWAM PKWY	HENDERSON	NV	89074
OPTU4524	OPTUMRX	2858 LOKER AVE E	CARLSBAD	CA	92010-6673
OPTU7847	OPTUMRX	6800 W 115TH ST	OVERLAND PARK	KS	66211-9838
WALG7972	WALGREEN CO.	1445 W CRAIG RD	NORTH LAS VEGAS	NV	89032-0211
NEVA6379	NEVADA CVS PHARMACY, L.L.C.	6432 LOSEE RD	NORTH LAS VEGAS	NV	89086-0100
WAL-8935	WAL-MART PHARMACY 10-5269	490 E SILVERADO RANCH BLVD	LAS VEGAS	NV	89183-6290
SMIT3174	SMITHS FOOD & DRUG CENTERS	8555 W SAHARA AVE	LAS VEGAS	NV	89117
WALG5026	WALGREEN CO.	8500 W CHEYENNE AVE	LAS VEGAS	NV	89129-7262
986 3894	986 SPECIALTY PHARMACY #2 INC.	241 N BUFFALO DR	LAS VEGAS	NV	89145-0312
WALG2789	WALGREEN CO.	401 N ARROYO GRANDE BLVD	HENDERSON	NV	89014-3974
NEVA9531	NEVADA CVS PHARMACY, L.L.C.	4800 W CHARLESTON BLVD	LAS VEGAS	NV	89146-1400
FAMI5981	FAMILY CARE PHARMACY	5625 S RAINBOW BLVD	LAS VEGAS	NV	89118-1855
WALG6622	WALGREEN CO.	6101 W LAKE MEAD BLVD	LAS VEGAS	NV	89108-2660
WALG0770	WALGREEN CO.	8633 W CHARLESTON BLVD	LAS VEGAS	NV	89117-5406
FIRS3108	FIRST CLASS RX PHARMACY LLC	3783 E DESERT INN RD	LAS VEGAS	NV	89121
WALG0561	WALGREEN CO.	9305 S EASTERN AVE	LAS VEGAS	NV	89123-6837

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ALBE7275	ALBERTSON'S LLC	4800 BLUE DIAMOND RD	LAS VEGAS	NV	89139-7602
SMIT3851	SMITH'S FOOD & DRUG CENTERS	2211 N RAMPART BLVD	LAS VEGAS	NV	89128
ALIR8181	ALIRAZA LLC DBA CITY PHARMACY	1131 E TROPICANA AVE	LAS VEGAS	NV	89119-6630
ALBE7225	ALBERTSON'S LLC	4850 W CRAIG RD	LAS VEGAS	NV	89130-2727
SMIT7992	SMITH'S FOOD & DRUG CENTERS	SMITH'S FOOD & DRUG #341	PAHRUMP	NV	89048
WALG4041	WALGREEN CO.	4771 W CRAIG RD	NORTH LAS VEGAS	NV	89032-2501
WAL-9750	WAL-MART PHARMACY 10-4557	3075 E TROPICANA AVE	LAS VEGAS	NV	89121-7311
SMIT8644	SMITH'S FOOD & DRUG #351	6130 W TROPICANA AVE	LAS VEGAS	NV	89103-4604
SAM'2391	SAM'S PHARMACY 10-6261	1910 E SERENE AVE	LAS VEGAS	NV	89123-3218
NEVA7984	NEVADA CVS PHARMACY, L.L.C.	8320 W CHEYENNE AVE	LAS VEGAS	NV	89129-2147
WALG5480	WALGREEN CO.	4875 S FORT APACHE RD	LAS VEGAS	NV	89147-7944
WARM2025	WARM SPRINGS ROAD CVS, L.L.C.	3210 N TENAYA WAY	LAS VEGAS	NV	89129-6239
SMIT2695	SMITH'S FOOD & DRUG CTRS INC	9750 S MARYLAND PKWY	LAS VEGAS	NV	89183-7119
WALG3977	WALGREEN CO.	2280 LAS VEGAS BLVD N	NORTH LAS VEGAS	NV	89030-5803
NEVA7972	NEVADA CVS PHARMACY, L.L.C.	5985 W TROPICANA AVE	LAS VEGAS	NV	89103-4814
WALG6631	WALGREEN CO.	3030 LAS VEGAS BLVD N	NORTH LAS VEGAS	NV	89030-5756
WALG7707	WALGREEN CO.	565 E CENTENNIAL PKWY	NORTH LAS VEGAS	NV	89081-5633
AVEL3211	AVELLA OF LAS VEGAS II	701 SHADOW LN	LAS VEGAS	NV	89106-4132
WALG2919	WALGREEN CO.	5082 E LAKE MEAD BLVD	LAS VEGAS	NV	89115
LIN'9043	LIN'S SUPERMARKETS INC #5	350 S MOAPA VALLEY BLVD	OVERTON	NV	89040
WAL-3423	WAL-MART PHARMACY 10-1838	3041 N RAINBOW BLVD	LAS VEGAS	NV	89108
K MA1774	K MART PHARMACY #3592	5051 E BONANZA RD	LAS VEGAS	NV	89110-3514
SAVE4820	SAVE MART PHARMACY #556	195 W PLUMB LN	RENO	NV	89509-3450
WARM9367	WARM SPRINGS ROAD CVS, L.L.C.	7285 S DURANGO DR	LAS VEGAS	NV	89113
WALG3586	WALGREEN CO.	2451 HAMPTON RD	HENDERSON	NV	89052-6964
TRIN1363	TRINITY PHARMACY LLC	2797 S MARYLAND PKWY	LAS VEGAS	NV	89109
WARM4208	WARM SPRINGS ROAD CVS, L.L.C.	7295 S RAINBOW BLVD	LAS VEGAS	NV	89118
WALG7616	WALGREEN CO.	7685 S RAINBOW BLVD	LAS VEGAS	NV	89139-5477
THE 0168	THE VONS COMPANIES INC	6450 SKY POINTE DR	LAS VEGAS	NV	89131

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WALG4025	WALGREEN CO.	2427 LAS VEGAS BLVD S	LAS VEGAS	NV	89104-2530
WARM2138	WARM SPRINGS ROAD CVS, L.L.C.	695 S GREEN VALLEY PKWY	HENDERSON	NV	89052-0404
NEVA4695	NEVADA CVS PHARMACY, L.L.C.	8116 LAS VEGAS BLVD S	LAS VEGAS	NV	89123-1015
PREC8107	PRECISION SPECIALTY PHARMACY	2775 S JONES BLVD	LAS VEGAS	NV	89146
SMIT5656	SMITH MANAGEMENT CORP	2540 S MARYLAND PKWY	LAS VEGAS	NV	89109-1627
ALBE3240	ALBERTSON'S LLC	1940 VILLAGE CENTER CIR	LAS VEGAS	NV	89134-6236
PART6749	PARTELL SPECIALTY PHARMACY	5835 S EASTERN AVE	LAS VEGAS	NV	89119-3031
WAL-8113	WAL-MART PHARMACY #10-2483	6973 BLUE DIAMOND RD	LAS VEGAS	NV	89178
WARM8840	WARM SPRINGS ROAD CVS, L.L.C.	4755 W ANN RD	NORTH LAS VEGAS	NV	89031-3424
WAL-3884	WAL-MART PHARMACY 10-3355	1400 S LAMB BLVD	LAS VEGAS	NV	89104
WARM8187	WARM SPRINGS ROAD CVS, L.L.C.	21 W HORIZON RIDGE PKWY	HENDERSON	NV	89012
SMIT4395	SMITH'S PHARMACY #367	9710 W SKYE CANYON PARK DR	LAS VEGAS	NV	89166-6569
WALG3085	WALGREEN CO.	5610 CENTENNIAL CENTER BLVD	LAS VEGAS	NV	89149-7104
WAL-6447	WAL-MART PHARMACY 10-3350	5198 BOULDER HWY	LAS VEGAS	NV	89122-6002
NEVA0369	NEVADA CVS PHARMACY, L.L.C.	6100 SPRING MOUNTAIN RD	LAS VEGAS	NV	89146-8805
ALBE7237	ALBERTSON'S LLC	11720 W CHARLESTON BLVD	LAS VEGAS	NV	89135-1572
WALG6914	WALGREEN CO.	3808 E TROPICANA AVE	LAS VEGAS	NV	89121
WALG5594	WALGREEN CO.	6390 BOULDER HWY	LAS VEGAS	NV	89122-7439
TLGR7278	TLGRX CORPORATION	8579 S EASTERN AVE	LAS VEGAS	NV	89123-2887
WALG1707	WALGREEN CO.	451 S DECATUR BLVD	LAS VEGAS	NV	89107-2805
NEVA1999	NEVADA CVS PHARMACY, L.L.C.	2011 E LAKE MEAD BLVD	NORTH LAS VEGAS	NV	89030-7135
COST4540	COSTCO WHOLESALE CORPORATION	6555 N DECATUR BLVD	LAS VEGAS	NV	89131-2796
WAL-5106	WAL-MART PHARMACY 10-2592	1807 W CRAIG RD	NORTH LAS VEGAS	NV	89032
WAL-0504	WAL-MART PHARMACY 10-1584	3615 S RAINBOW BLVD	LAS VEGAS	NV	89103-1057
WARM2102	WARM SPRINGS ROAD CVS, L.L.C.	350 W LAKE MEAD PKWY	HENDERSON	NV	89015
BENZ3996	BENZENE KHEMIKALS LLC	3050 E BONANZA RD	LAS VEGAS	NV	89101
ALBE7314	ALBERTSON'S LLC	10250 W CHARLESTON BLVD	LAS VEGAS	NV	89135-1020
QHR 4350	QHR PHARMACY 1	765 N NELLIS BLVD	LAS VEGAS	NV	89110
WELL8964	WELL CARE DISCOUNT PHARMACY	3300 W CHARLESTON BLVD	LAS VEGAS	NV	89102

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WALG3970	WALGREEN CO.	1101 LAS VEGAS BLVD S	LAS VEGAS	NV	89104-1305
WAL-7705	WAL-MART PHARMACY 10-2884	8060 W TROPICAL PKWY	LAS VEGAS	NV	89149
WARM7414	WARM SPRINGS ROAD CVS, L.L.C.	60 N VALLE VERDE DR	HENDERSON	NV	89074-1756
NEVA5889	NEVADA CVS PHARMACY, L.L.C.	1600 N BUFFALO DR	LAS VEGAS	NV	89128-8900
WALG8239	WALGREEN CO.	2995 E FLAMINGO RD	LAS VEGAS	NV	89121-5214
TRUE3501	TRUE CARE PHARMACY 3	2208 S NELLIS BLVD	LAS VEGAS	NV	89104
DOLC0624	DOLCRX	801 S RANCHO DR	LAS VEGAS	NV	89106-3870
SAM'8610	SAM'S CLUB PHARMACY 10-4983	7100 ARROYO CROSSING PKWY	LAS VEGAS	NV	89113-4057
SMIT0909	SMITH'S FOOD & DRUG CENTERS	830 S BOULDER HWY	HENDERSON	NV	89015-7521
WALG9623	WALGREEN CO.	900 N RANCHO DR	LAS VEGAS	NV	89106-1005
ADVA7852	ADVANCED CARE RX PHARMACY 1	7512 WESTCLIFF DR	LAS VEGAS	NV	89145-5175
SMIT6724	SMITH'S PHARMACY #306	2255 LAS VEGAS BLVD N	NORTH LAS VEGAS	NV	89030
NEVA7996	NEVADA CVS PHARMACY, L.L.C.	1408 W CRAIG RD	NORTH LAS VEGAS	NV	89032-0210
SMIT9162	SMITH'S FOOD & DRUG CENTERS	4600 E SUNSET RD	HENDERSON	NV	89014-2202
ALBE7364	ALBERTSON'S LLC	201 S STEPHANIE ST	HENDERSON	NV	89012
GREE6454	GREEN VALLEY PHARMACY	2245 N GREEN VALLEY PKWY	HENDERSON	NV	89014-5024
WALG6431	WALGREEN CO.	1360 W HORIZON RIDGE PKWY	HENDERSON	NV	89012-2462
ALBE7162	ALBERTSON'S LLC	7075 W ANN RD	LAS VEGAS	NV	89130-1109
NEVA1013	NEVADA CVS PHARMACY, L.L.C.	1402 E LAKE MEAD PKWY	HENDERSON	NV	89015-4600
SMIT2703	SMITH'S FOOD & DRUG CTRS	4015 S BUFFALO DR	LAS VEGAS	NV	89147
WALG7791	WALGREEN CO.	4895 BOULDER HWY	LAS VEGAS	NV	89121
NEVA5079	NEVADA CVS PHARMACY, L.L.C.	5681 BOULDER HWY	LAS VEGAS	NV	89122-7201
CNS 8639	CNS SCRIPS, LLC	3370 PINKS PL	LAS VEGAS	NV	89102-8415
WARM2013	WARM SPRINGS ROAD CVS, L.L.C.	605 N STEPHANIE ST	HENDERSON	NV	89014-2612
NEVA4586	NEVADA CVS PHARMACY, L.L.C.	1551 W SUNSET RD	HENDERSON	NV	89014-6636
ALBE7287	ALBERTSON'S LLC	10140 W FLAMINGO RD	LAS VEGAS	NV	89147-8385
WAL-5211	WAL-MART PHARMACY 10-2050	300 E LAKE MEAD PKWY	HENDERSON	NV	89015-5576
LONG1494	LONGS DRUG STORES CALIFORNIA, L.L.C.	9430 DEL WEBB BLVD	LAS VEGAS	NV	89134-8314
NEVA5284	NEVADA CVS PHARMACY, L.L.C.	4014 S RAINBOW BLVD	LAS VEGAS	NV	89103-2011

Store ID	Name	Address	City	State	Zip
WALG0857	WALGREEN CO.	9300 W SAHARA AVE	LAS VEGAS	NV	89117-5351
LIFE5492	LIFEFIRST PHARMACY, LLC	2407 W CHARLESTON BLVD	LAS VEGAS	NV	89102-2138
WARM7369	WARM SPRINGS ROAD CVS, L.L.C.	3645 LAS VEGAS BLVD S	LAS VEGAS	NV	89109-4321
WALG2642	WALGREEN CO.	9415 W DESERT INN RD	LAS VEGAS	NV	89117-6765
WAL-5080	WAL-MART PHARMACY 10-5101	300 S HIGHWAY 160	PAHRUMP	NV	89048-2132
WAL-0997	WAL-MART PHARMACY 10-4339	5940 LOSEE RD	NORTH LAS VEGAS	NV	89081-6591
WARM2140	WARM SPRINGS ROAD CVS, L.L.C.	6371 N DECATUR BLVD	LAS VEGAS	NV	89130-8001
WAL-8947	WAL-MART PHARMACY 10-5306	5545 SIMMONS ST	NORTH LAS VEGAS	NV	89031-9005
WALG3321	WALGREEN CO.	329 N SANDHILL BLVD	MESQUITE	NV	89027-4729
NEVA2209	NEVADA CVS PHARMACY, L.L.C.	3810 E SUNSET RD	LAS VEGAS	NV	89120-3917
WARM2075	WARM SPRINGS ROAD CVS, L.L.C.	6480 SKY POINTE DR	LAS VEGAS	NV	89131-4038
SMIT3088	SMITH'S PHARMACY #315	8525 W WARM SPRINGS RD	LAS VEGAS	NV	89113-3625
WALG5873	WALGREEN CO	6495 N DECATUR BLVD	LAS VEGAS	NV	89131
WALG0891	WALGREEN CO.	4905 W TROPICANA AVE	LAS VEGAS	NV	89103-5077
WALG5970	WALGREEN CO.	3821 W FLAMINGO RD	LAS VEGAS	NV	89103
WAL-1948	WAL-MART PHARMACY 10-4356	7200 ARROYO CROSSING PKWY	LAS VEGAS	NV	89113-4058
ALBE7251	ALBERTSON'S LLC	1001 S RAINBOW BLVD	LAS VEGAS	NV	89145-6232
NEVA2872	NEVADA CVS PHARMACY, L.L.C.	6705 E LAKE MEAD BLVD	LAS VEGAS	NV	89156-1101
PHAR2236	PHARMACY ALTERNATIVES CALIFORNIA, LLC	2940 E LA PALMA AVE	ANAHEIM	CA	92806-2619
PHAR0152	PHARMACY ALTERNATIVES CALIFORNIA LLC	2940 E LA PALMA AVE	ANAHEIM	CA	92806
WALG7144	WALGREEN CO.	2400 E TROPICANA AVE	LAS VEGAS	NV	89121-5441
WARM2126	WARM SPRINGS ROAD CVS, L.L.C.	7090 N 5TH ST	NORTH LAS VEGAS	NV	89084
SMIT9256	SMITH'S MANAGEMENT CORP	450 N NELLIS BLVD	LAS VEGAS	NV	89110-5304
STUD4301	STUDENT HEALTH PHARMACY	4505 S MARYLAND PKWY	LAS VEGAS	NV	89154-9900
WALG2039	WALGREEN CO.	495 FREMONT ST	LAS VEGAS	NV	89101
THE 2505	THE VONS COMPANIES INC	1155 E TWAIN AVE	LAS VEGAS	NV	89169-4208
NEVA4596	NEVADA CVS PHARMACY, L.L.C.	8491 FARM RD	LAS VEGAS	NV	89131-8241

Therapeutic Class Summary

Therapeutic Class 4	Script Count	Patient Count	Pharmacy Count
GENERAL ANESTHETICS, MISCELLANEOUS	101	20	6
OREXIN RECEPTOR ANTAGONISTS	9	5	6
BARBITURATES (ANXIOLYTIC, SEDATIVE/HYP)	8	4	4
AMPHETAMINE DERIVATIVES	5	3	4
ANTIDEPRESSANTS, MISCELLANEOUS	1	1	1
CENTRALLY ACTING SKELETAL MUSCLE RELAXNT	3	1	1
ANXIOLYTICS,SEDATIVES,AND HYPNOTICS,MISC	294	103	73
ANDROGENS	1	1	1
AMPHETAMINES	1009	330	176
RESPIRATORY AND CNS STIMULANTS	46	19	20
ANTICONVULSANTS, MISCELLANEOUS	19	7	6
WAKEFULNESS-PROMOTING AGENTS	18	10	10
BENZODIAZEPINES (ANTICONVULSANTS)	365	134	104
OPIATE AGONISTS	28	11	10
OPIATE PARTIAL AGONISTS	706	164	106
BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)	1123	346	187

Disclaimer:

By proceeding beyond this page and accessing this Prescription Monitoring Program (PMP) system, I certify that I am currently registered and authorized to prescribe or dispense controlled substances, or the duly authorized delegate thereof. I understand that my use of this PMP system is permitted only in connection with providing medical or pharmaceutical care to a patient, which includes evaluating a patient for medical treatment, and only to the extent authorized by law. I understand that my access to or disclosure of any PMP data for any purpose not authorized by law may subject me to disciplinary action, civil penalties, or criminal prosecution. I further understand that I must treat the information in the PMP system as confidential, just as I would any other protected health information. I will protect any PMP information in my possession in accordance with Federal and state laws governing protected health information. I understand that I am responsible for all use of my username and password. I will never share my password with anyone, including my co-workers and staff. If my authentication or password is lost or compromised, I agree to notify the PMP immediately. I understand the PMP will monitor for unusual or potentially unauthorized use of the system.

EXHIBIT 7

EXHIBIT 7

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 8

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EXHIBIT 9

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EXHIBIT 10

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EXHIBIT 11

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EXHIBIT 12

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EXHIBIT 30

EXHIBIT 30

Guidelines for the Chronic Use of Opioid Analgesics

Adopted as policy by the Federation of State Medical Boards
April 2017

INTRODUCTION

In April 2015, the Federation of State Medical Boards (FSMB) Chair, J. Daniel Gifford, MD, FACP, appointed the Workgroup on FSMB's *Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain* to review the current science for treating chronic pain with opioid analgesics and to revise the Model Policy as appropriate.

To accomplish this charge, the workgroup conducted a thorough review and analysis of FSMB's existing policy document and other state and federal policies on the prescribing of opioids in the treatment of pain, including the March 2016 *CDC Guideline for Prescribing Opioids for Chronic Pain* (https://www.cdc.gov/drugoverdose/prescribing/guideline.html)

In updating its existing policy, the FSMB sought input from a diverse group of medical and policy stakeholders that ranged from experts in pain medicine and addiction to government officials and other thought leaders. Over the course of the last 12 months, the workgroup met on several occasions to examine and explore the key elements required to ensure FSMB's policy document remains relevant and is sufficiently comprehensive to serve as a prescribing guideline and resource for state medical and osteopathic boards and clinicians.

This policy document includes relevant recommendations identified by the workgroup, and is in keeping with recent releases of advisories issued by the CDC and FDA. This policy is intended as a resource providing overall guidance to state medical and osteopathic boards in assessing physicians' management of pain in their patients and whether opioid analgesics are used in a medically appropriate manner.

FSMB GUIDELINES FOR THE CHRONIC USE OF OPIOID ANALGESICS

Section 1 – PREAMBLE

The diagnosis and treatment of pain is integral to the practice of medicine[2,18-21]. In order to implement best practices for responsible opioid prescribing, clinicians must understand the relevant pharmacologic and clinical issues in the use of opioid analgesics and should obtain sufficient targeted continuing education and training on the safe prescribing of opioids and other analgesics as well as training in multimodal treatments.

Section 2 – FOCUS OF GUIDELINES

The focus of the Guidelines that follow is on the general overall safe and evidence-based prescribing of opioids and treatment of chronic, non-cancer pain with the specific **limitation and restriction** that these Guidelines do not operate to create any specific standard of care, which standard must depend upon fact-specific totality of circumstances surrounding specific quality-of-care events. The Guidelines recognize that there is not just one appropriate strategy to accomplish the goals of these Guidelines. Effective means of achieving the goals of these Guidelines vary widely depending on the type and causes of the patient's pain, the preferences of the clinician and the patient, the resources available at the time of care, and other concurrent issues beyond the scope of these Guidelines.

These Guidelines that follow do not encourage the prescribing of opioids over other pharmacological and nonpharmacological means of treatment but rather the Guidelines recognize the responsibility of clinicians to view pain management as essential to quality of medical practice and to the quality of life for patients who suffer from pain.

Finally, the Guidelines that follow are not intended for the treatment of acute pain, acute pain management in the perioperative setting, emergency care, cancer-related pain, palliative care, or end-of-life care. These Guidelines may apply most directly to the treatment of chronic pain lasting more than three months in duration or past the time of normal tissue healing, however many of the strategies mentioned here are also relevant to responsible prescribing and the mitigation of risks associated with other controlled substances in the treatment of pain.

Section 3 – DEFINITIONS

For the purposes of this Model Policy, the following terms are defined as shown.

Aberrant Behaviors: Certain behaviors may constitute aberrant behaviors. For example, obtaining prescriptions for the same or similar drugs from more than one clinician or other health care provider without the treating clinician's knowledge is aberrant behavior, as is use of illicit drugs.

Abuse: Abuse has been described as a pattern of drug use that exists despite adverse consequences or risk of consequences. Abuse of a prescription medication involves its use in a manner that deviates from accepted medical, legal, and social standards, generally to achieve a euphoric state ("high") or that is other than the purpose for which the medication was prescribed[14]. Please also see "Substance Use Disorder".

Addiction: A common definition of addiction is that it is "a primary, chronic, neurobiologic disease, whose development and manifestations are influenced by genetic, psychosocial, and environmental factors"[14]. Addiction often is said to be characterized by behaviors that include impaired control over drug use, craving, compulsive use, and continued use despite harm[14]. A newer definition, adopted by the American Society of Addiction Medicine in 2011, describes addiction as "a primary, chronic disease of brain reward, motivation, memory and related

circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death"[24]. (As discussed below, physical dependence and tolerance are expected physiological consequences of extended opioid therapy for pain and in this context do not indicate the presence of addiction.) Please also see "Substance Use Disorder".

Controlled Substance: A controlled substance is a drug that is subject to special requirements under the federal Controlled Substances Act of 1970 (CSA)[13], which is designed to ensure both the availability and control of regulated substances. Under the CSA, availability of regulated drugs for medical purposes is accomplished through a system that establishes quotas for drug production and a distribution system that closely monitors the importation, manufacture, distribution, prescribing, dispensing, administering, and possession of controlled drugs. Civil and criminal sanctions for serious violations of the statute are part of the government's control apparatus. The Code of Federal Regulations (Title 21, Chapter 2) implements the CSA. The CSA provides that responsibility for scheduling controlled substances is shared between the Food and Drug Administration (FDA) and the DEA. In granting regulatory authority to these agencies, the Congress noted that both public health and public safety needs are important and that neither takes primacy over the other. To accomplish this, the Congress provided guidance in the form of factors that must be considered by the FDA and DEA when assessing public health and safety issues related to a new drug or one that is being considered for rescheduling or removal from control.

The CSA does not limit the amount of drug prescribed, the duration for which it is prescribed, or the period for which a prescription is valid (although some states do impose such limits).

Most potent opioid analgesics are classified in Schedules II under the CSA, indicating that they have a significant potential for abuse and a currently accepted medical use in treatment in the U.S. (with certain restrictions), and that abuse of the drug may lead to severe psychological or physical dependence. Although the scheduling system provides a rough guide to abuse potential, all controlled medications have some potential for abuse.

Dependence: Physical dependence is a state of biologic adaptation that is evidenced by a withdrawal syndrome when the drug is abruptly discontinued or the dose rapidly reduced, and/or by the administration of an antagonist[14]. It is important to distinguish addiction from the type of physical dependence that can and does occur within the context of good medical care, as when a patient on long-term opioid analgesics for pain becomes physically dependent on the analgesic. This distinction is reflected in the two primary diagnostic classification systems used by health care professionals: the *International Classification of Mental and Behavioral Disorders, 10th Edition* (ICD-10) of the World Health Organization[50], and the *Diagnostic and Statistical Manual (DSM)* of the American Psychiatric Association[51], In the DSM-IV-TR, a

diagnosis of “substance dependence” meant addiction. In the DSM-5, the term *dependence* is reestablished in its original meaning of physiological dependence. When symptoms are sufficient to meet criteria for substance misuse or addiction, the term “substance use disorder” is used, accompanied by severity ratings[49].

It may be important to clarify this distinction during the informed consent process, so that the patient (and family) understands that physical dependence and tolerance are likely to occur if opioids are taken regularly over a period of time, but that the risk of addiction is relatively low, although estimates do vary. Discontinuing chronic opioid therapy may be difficult, even in the absence of addiction. According to the World Health Organization, “The development of tolerance and physical dependence denote normal physiologic adaptations of the body to the presence of an opioid”[50]. Consequently, physical dependence alone is neither necessary nor sufficient to diagnose addiction[51,52]. Please also see "Substance Use Disorder".

Diversion: Drug diversion is defined as the intentional transfer of a controlled substance from authorized to unauthorized possession or channels of distribution[53-54]. The federal Controlled Substances Act (21 U.S.C. §§ 801 et seq.) establishes a closed system of distribution for drugs that are classified as controlled substances. Records must be kept from the time a drug is manufactured to the time it is dispensed. Health care professionals who are authorized to prescribe, dispense, and otherwise control access to such drugs are required to register with the DEA[13,55].

Pharmaceuticals that make their way outside this closed distribution system are said to have been “diverted”[55], and the individuals responsible for the diversion (including patients) are in violation of federal law, and often corresponding state laws as well.

Experience shows that the degree to which a prescribed medication is misused depends in large part on how easily it is redirected (diverted) from the legitimate distribution system[7,8,54].

Misuse: The term misuse (also called nonmedical use) encompasses all uses of a prescription medication other than those that are directed by a clinician and used by a patient within the law and the requirements of good medical practice[14]. Please also see "Substance Use Disorder".

Opioid: An opioid is an opium-like compound that binds to one or more of the three opioid receptors of the body. The class includes naturally occurring and synthetic or semi-synthetic opioid drugs or medications, as well as endogenous opioid peptides[19]. Most clinicians use the terms “opiate” and “opioid” interchangeably, but toxicologists (who perform and interpret drug tests) make a clear distinction between them. “Opioid” is the broader term because it includes the entire class of agents that act at opioid receptors in the CNS, whereas “opiates” refers to natural compounds derived from the opium plant but not semisynthetic opioid derivatives of opiates or completely synthetic agents. Thus, drug tests that are “positive for opiates” have detected one of these compounds or a metabolite of heroin, 6-monoacetyl morphine (MAM). Drug tests that are “negative for opiates” have found no detectable levels of opiates in the sample, even though other opioids that were not tested for—including the most common currently used and misused prescription opioids—may be present in the sample that was analyzed[34,40-41].

Pain: An unpleasant and potentially disabling sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. *Acute pain* is the normal, predictable physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Acute pain generally is time limited, lasting six weeks or less[2]. *Chronic pain* is a state in which pain persists beyond the usual course of an acute disease or healing of an injury (e.g., more than three months). It may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over a period of months or years. *Chronic non-cancer related pain* is chronic pain that is not associated with cancer and does not occur at the end of life[2,56]. *Opioid-induced hyperalgesia* may develop as a result of long-term opioid use in the treatment of pain. *Primary hyperalgesia* is pain sensitivity that occurs directly in the damaged tissues, while *secondary hyperalgesia* occurs in surrounding undamaged tissues. Human and animal studies have demonstrated that primary or secondary hyperalgesia can develop in response to both chronic and acute exposure to opioids. Hyperalgesia can be severe enough to warrant discontinuation of opioid treatment[57].

Prescription Drug Monitoring Program: As a patient safety tool, almost all states have enacted laws that establish prescription drug monitoring programs (PDMPs) to facilitate the collection, analysis, and reporting of information on the prescribing and dispensing of controlled substances. Most such programs employ electronic data transfer systems, under which prescription information is transmitted from the dispensing pharmacy to a state agency, which collates and analyzes the information[1,12]. After analyzing the efficacy of PDMPs, the Government Accountability Office (GAO) concluded that such programs have the potential to help law enforcement and regulatory agencies rapidly identify and investigate activities that may involve illegal prescribing, dispensing or consumption of controlled substances. Where real-time data are available, PDMPs also can help to prevent prescription drug misuse, overdose, and diversion by allowing clinicians to determine whether a patient is receiving prescriptions for controlled substances from other clinicians, as well as whether the patient has filled or refilled an order for an opioid the clinician has prescribed[12,58-59].

Substance Use Disorder: In the DSM-5, Substance Use Disorder encompasses what was previously classified as abuse, dependence, misuse, and tolerance. Under the DSM-5 definition of Substance Use Disorder a patient needs to meet any 2 of 11 criteria in the same 12 months. The severity is based on the number of criteria (i.e., mild is 2-3 criteria, moderate is 4-5 criteria, and severe is 6 or more criteria). Criteria are grouped into impaired control (i.e., taken in larger amounts or over longer time than was intended; persistent desire or unsuccessful efforts to cut down or control use; great deal of time spent in activities to obtain, use or recover from its effects; craving or strong desire to use); social impairment (i.e., use resulting in a failure to fulfill major role obligations at work, school, or home; continued use despite persistent or recurrent social or interpersonal problems caused by the use; important social, occupational, or recreational activities are given up or reduced due to use); risky use (i.e., recurrent use in situations in which it is physically dangerous; use despite knowledge of having a persistent physical or psychological problem that is caused or exacerbated by use); and pharmacological properties (i.e, tolerance; withdrawal).

Tolerance: Tolerance is a state of physiologic adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug's effects over time. Tolerance is common in opioid treatment and is not the same as addiction[14]. Please also see "Substance Use Disorder".

Section 3 - FSMB GUIDELINES

State medical boards may adopt the following criteria for use in evaluating a clinician's management of a patient with pain, including the clinician's prescribing of opioid analgesics. Such adoption is subject to the **Guidelines, Limitations and Restrictions** previously set forth.

Patient Evaluation and Risk Stratification

The medical record should document the presence of one or more recognized medical indications and absence of psychosocial contraindications for prescribing an opioid analgesic[3] and reflect an appropriately detailed patient evaluation[22]. An evaluation should be completed and documented concurrent with the decision of whether to prescribe an opioid analgesic.

The nature and extent of the evaluation depends on the type of pain and the context in which it occurs. Assessment of the patient's pain should include the nature and intensity of the pain, past and current treatments for the pain, any underlying or co-occurring disorders and conditions, and the effect of the pain on the patient's physical and psychological functioning [17].

For every patient, the initial assessment and evaluation should include a systems review and relevant physical examination, as well as objective markers of disease or diagnostic markers as indicated. Also, functional assessment, including social and vocational assessment, is useful in identifying supports and obstacles to treatment and rehabilitation.

Assessment of the patient's personal and family history of alcohol or drug abuse and relative risk for substance use disorder also should be part of the initial evaluation[5,6,9-11,27], and ideally should be completed prior to a decision as to whether to prescribe opioid analgesics[37-39]. This can be done through a careful clinical interview, which should also inquire into any history of physical, emotional or sexual abuse, because those are risk factors for substance use disorder[17]. Use of validated screening tools for substance use disorder may be used for collecting and evaluating information and determining the patient's level of risk.

Patients who have a history of substance use disorder as defined by DSM-5 are at an elevated risk for failure of opioid analgesic therapy to achieve the goals of improved comfort and function, and also are at high risk for relapse. Treatment of a patient who has a history of substance use disorder may involve consultation with an addiction specialist before opioid therapy is initiated (and follow-up, as needed). Additionally, patients who have a substance use disorder as defined by the DSM-5, require additional support if opioid therapy is necessitated and should not receive opioid therapy until they are established in a treatment/recovery program[17] or alternatives are established, such as co-management with an addiction professional. Clinicians who treat patients with chronic pain are encouraged to also be knowledgeable about the identification and treatment of substance use disorder, including the

role of replacement agonists such as methadone and buprenorphine. Some non-addiction specialist clinicians may choose to directly treat patients with substance use disorder. This may include becoming eligible to treat substance use disorder using office-based buprenorphine as part of medication-assisted treatment.

Assessment of the patient's personal and family history of mental health disorders should be part of the initial evaluation, and ideally should be completed prior to a decision as to whether to prescribe opioid analgesics. All patients should be screened for depression and other mental health disorders, as part of risk evaluation. Patients with untreated depression and other mental health disorders are at increased risk for misuse or abuse of controlled medications, including addiction and overdose. Additionally, untreated depression can interfere with the resolution of pain.

The patient evaluation may include information from family members and/or significant others[10-11,31-32]. It is strongly recommended that the state prescription drug monitoring program (PDMP) be consulted prior to initiating opioid therapy and at appropriate intervals thereafter to determine whether the patient is receiving prescriptions from any other clinicians, and the results obtained from the PDMP should be reviewed.

In working with a patient who is taking opioids prescribed by another clinician—particularly a patient on high doses—the evaluation and risk stratification assume even greater importance[9-11]. Therefore, to ensure a smooth transition of care, clinicians are encouraged to collaborate with the primary prescriber.

Caution should be used with the administration of chronic opioids in women of childbearing age, as chronic opioid therapy during pregnancy increases risk of harm to the newborn. Opioids should be administered with caution in breastfeeding women, as some opioids may be transferred to the baby in breast milk. When chronic opioid therapy is used for an elderly patient, clinicians should carefully consider the initial dose, titrating slowly upwards if necessary, using a longer dosing interval, and monitoring more frequently. Patients at risk for sleep disordered breathing are at increased risk for harm with the use of chronic opioid therapy. Clinicians should consider the use of a screening tool for obstructive sleep apnea and refer patients for proper evaluation and treatment when indicated.

The patient evaluation should include most of the following elements:

- Medical history and physical examination targeted to the pain condition
- Nature and intensity of the pain
- Current and past treatments, including interventional treatments, with response to each treatment
- Underlying or co-existing diseases or conditions, including those which could complicate treatment (i.e. obesity, renal disease, sleep apnea, COPD, etc.)
- Effect of pain on physical and psychological functioning
- Personal and family history of substance use disorder
- History of psychiatric disorders (bipolar, ADD/ADHD, sociopathic, borderline, major depressive disorder)

- Post-traumatic stress disorder (PTSD)
- Medical indication(s) for use of opioids
- Review of the PDMP results
- Obtain consultation with other clinicians when applicable
- Urine, blood or other types of biological samples and diagnostic markers

Development of a Treatment Plan and Goals

The goals of pain treatment include reasonably attainable improvement in pain to decrease suffering and to increase function; improvement in pain-associated symptoms such as sleep disturbance, depression, and anxiety; screening for side effects of treatment; and avoidance of unnecessary or excessive use of medications[2,4]. There should be a balance between monitoring for efficacy and side effects with the use of medications for the shortest duration appropriate.

The treatment plan and goals should be established as early as possible in the treatment process and revisited regularly, so as to provide clear-cut, individualized objectives to guide the choice of therapies[22] for both the clinician and the patient.

The treatment plan may contain information supporting the selection of therapies, both pharmacologic (medications other than opioids to include anti-inflammatories, acetaminophen, and selected antidepressants and anticonvulsants) interventional, and non-pharmacologic therapies such as cognitive behavioral therapy, massage, exercise, multimodal pain treatment, and osteopathic manipulative treatment. The plan should document any further diagnostic evaluations, consultations or referrals, or additional therapies that have been considered to the extent they are available.

Informed Consent and Treatment Agreement

The decision to initiate chronic opioid therapy is a shared decision between the clinician and the patient. The clinician should discuss the risks and benefits of the treatment plan (including any proposed use of opioid analgesics) with the patient. If opioids are prescribed, the patient (and possibly family members) should be counseled on the potential risks and anticipated benefits, adverse effects of opioids, including but not limited to dependence, substance use disorder, overdose and death, as well as the safe ways to store and dispose of medications.

Use of a written informed consent and treatment agreement is recommended for long-term chronic opioid therapy[9-11,19,22]. Treatment agreements outline the joint responsibilities of the clinician and patient, including the patient's agreement to periodic and unannounced drug testing for opioids and other medications when deemed appropriate by the clinician with potential for substance use disorder as well as discuss with the patient how and when the PDMP will be reviewed as part of the patient's care.

Informed consent may address:

- Limited evidence as to the benefit of opioids or other pharmaceutical therapies in the management of chronic pain (except for cancer)

- Potential risks and benefits of opioid therapy
- Potential side effects (both short and long term), such as cognitive impairment and constipation
- The likelihood that tolerance to and physical dependence on the medication will develop
- Risk of drug interactions and over-sedation
- Risk of impaired motor skills (affecting driving and other tasks)
- Risk of substance use disorder, overdose and death
- The clinician's prescribing policies and expectations, including the number and frequency of prescription refills, early refills and replacement of lost or stolen medications
- Reasons for which drug therapy may be changed or discontinued (including violation of the treatment agreement) or that treatment may be discontinued without agreement by the patient.
- Education of the patient that the complete elimination of pain is not to be expected.

Treatment agreements outline the joint responsibilities of the clinician and patient[19-21] and are indicated for opioid or other medications with potential for substance use disorder. It is strongly recommended that treatment agreements include:

- Treatment goals in terms of pain management, restoration of function and safety
- Patient's responsibility for safe medication use (not taking more than prescribed; dangers of using in combination with alcohol, cannabis, or other substances like benzodiazepines unless closely monitored by the prescriber, etc.)
- Secure storage and safe disposal
- Patient's responsibility to obtain prescribed opioids from only one clinician or practice
- Patient's responsibility of getting the prescriptions filled at only one pharmacy
- Patient's agreement to periodic drug testing
- Clinician's responsibility to be available or to have a covering clinician available to care for unforeseen problems and to prescribe scheduled refills.

Clinicians are recommended to refrain from referring patients to the emergency department to obtain prescriptions for opioids for chronic pain that is not cancer-related or as part of palliative care or end-of-life care.

Initiating an Opioid Trial

Non-opioid and non-pharmacologic treatments should be considered before initiating opioid therapy for chronic or acute pain lasting beyond the expected duration.

When a decision is made to initiate opioid therapy, it should be presented to the patient as a therapeutic trial or test for a defined period of time (usually no more than 30 days) and with specified evaluation points including improvement in pain and function.

The clinician should explain that progress will be carefully monitored for both benefit and harm in terms of the effects of opioids on the patient's level of pain, function, and quality of life, as well as to identify any adverse events or risks to safety[33].

As noted by the FDA, when initiating opioid therapy for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment, it is highly recommended that the lowest dose possible be given, beginning with a short acting opioid and/or rotating to a long acting/extended release, if indicated. Prescribers may download a medication guide of all extended-release opioids for patients at http://www.accessdata.fda.gov/scripts/cder/daf/. A patient counseling document available in English and Spanish through the extended-release, long-acting Risk Evaluation and Mitigation Strategy (REMS) is also available for download at http://www.er-la-opioidrems.com/IwgUI/rems/pcd.action.

The concurrent use of benzodiazepines and opioids, recently added as a Black Box warning by the FDA, greatly increases the risk of adverse events including death. Given this increased risk, clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

While there is clinical variation in response by patients to opioid therapy at any given dosage, the CDC and some states have recommended specific dosing guidelines for opioids. Clinicians need to be aware that increasing opioid dosage beyond the current recommended guidelines may result in increased risk for substance use disorder and/or diversion. A clinician should clearly state in the medical records the rationale for using higher dosages than the current recommended guidelines, recognizing that genetic variations can significantly alter drug response, and monitor those patients prescribed such a dose with increased vigilance to assure the risks of diversion and/or overdose are minimized. The clinician should also be aware that maximum benefit to the patient may have already been obtained and increasing the dosage may not result in further therapeutic benefit, and can result in harm to the patient. Referral to, or consultation with a pain specialist for patients on higher than recommended dosages, may be considered, and dosages should not be escalated without re-evaluation of the benefits and risks.

Before prescribing methadone for its analgesic effect, it is strongly recommended that clinicians have specific training and/or experience as individual responses to methadone vary widely increasing the risk of overdose. There is a complex relationship between dose, half-life, duration of analgesic effect, and duration of respiratory depression. Specifically, the duration of analgesic effect is generally shorter than the duration of respiratory depression. The long half-life of methadone and the longer duration of respiratory depression relative to analgesia places patients at risk for overdose when titrating methadone dose for pain management.

Clinicians should consider co-prescribing naloxone for home use for all patients with opioid prescriptions in case of accidental or intentional overdose by the patient or household contacts. Patients at greatest risk of overdose include patients with a history of substance use disorder, history of prior overdose, clinical depression, patients who are taking opioids with other central nervous system depressants, or when evidence of increased risk by other measures exists (behaviors, family history, PDMP, risk assessment results).

Ongoing Monitoring and Adapting the Treatment Plan

The clinician should regularly review the patient's progress, including any new information about the etiology of the pain or the patient's overall health and level of function[19,31-32]. When possible, collateral information about the patient's response to opioid therapy may be obtained from family members or other close contacts, as well as review of the state PDMP. The patient may be seen more frequently while the treatment plan is being initiated and the opioid dose adjusted[26-33]. As the patient is stabilized in the treatment regimen, follow-up visits may be scheduled as indicated by stability and risk level. Monitoring plans for a given patient should take into account the generally increased risk for dependence developing a substance use disorder and misuse the longer the patient uses them.

Continuation, modification or termination of opioid therapy for pain is contingent on the clinician's evaluation of (1) evidence of the patient's progress toward treatment objectives and (2) the absence of substantial risks or adverse events, such as signs of substance use disorder and/or diversion[9-11,27]. A satisfactory response to treatment would be indicated by a reduced level of pain, increased level of function, and/or improved quality of life[15]. Information from family members or other caregivers may be considered in evaluating the patient's response to treatment[6,19-20]. Use of measurement tools to assess the patient's level of pain, function, and quality of life may be helpful in documenting therapeutic outcomes[6,31].

Periodic and Unannounced Drug Testing

Periodic and unannounced drug testing (including chromatography) are useful in monitoring adherence to the treatment plan, as well as in detecting the use of non-prescribed drugs[34-35]. Drug testing is an important monitoring tool because self-reporting of medication use is not always reliable and behavioral observations may detect some problems but not others[36-40]. It is strongly recommended that patients being treated for addiction be tested as frequently as necessary to ensure therapeutic adherence, but for patients being treated for pain, clinical judgment trumps recommendations for frequency of testing.

Urine may be the preferred biologic specimen for testing because of its ease of collection and storage and the cost-effectiveness of such testing[34]. When such testing is conducted as part of pain treatment, forensic standards are generally not necessary and not in place. Collection is preferably observed especially in pain clinics; however, chain-of-custody protocols are not followed. To help ensure a valid specimen, the urine should be warm and urine specific gravity and creatinine should be measured. Initial testing may be done using class-specific immunoassay drug panels (point-of-care or laboratory-based), which typically do not identify particular drugs within a class unless the immunoassay is specific for that drug. If necessary, this can be followed up with a more specific technique, such as gas chromatography/mass spectrometry (GC/MS) or other chromatographic tests to confirm the presence or absence of a specific drug or its metabolites[34]. In drug testing in a pain practice, it is important to identify the specific drug and metabolites, not just the class of the drug.

Clinicians need to be aware of the limitations of available tests (such as their limited sensitivity for many opioids) and take care to order tests appropriately[35]. For example, when a drug test is ordered, it is important to specify that it include the opioid being prescribed[34]. Because of the complexities involved in interpreting drug test results, it is advisable to confirm significant or unexpected results with the laboratory toxicologist or a clinical pathologist[40-41].

While immunoassay, point of care (POC) testing has its utility in the making of temporary and "on the spot" changes in clinical management, its limitations with regard to accuracy have recently been the subject of study. These limitations are such that point of care testing may not be appropriate for making definitive changes in medication management in populations at high risk for adverse outcomes until the results of confirmatory testing with more accurate methods such as liquid chromatography tandem mass spectrometry (LC-MS/MS) are obtained. A recent study on LC-MS/MS results following immunoassay POC testing in substance use disorder treatment settings found very high rates of "false negatives and positives"[34,60].

Test results that suggest opioid misuse should be discussed with the patient. It is helpful to approach such a discussion in a positive, supportive fashion, so as to strengthen the physician-patient relationship and encourage healthy behaviors (as well as behavioral change where that is needed). It is recommended that both the test results and subsequent discussion with the patient be documented in the medical record[34].

Adapting Treatment

As noted earlier, clinicians are encouraged to consult the state's PDMP before initiating opioids for pain and during ongoing therapy. A PDMP is important in monitoring compliance with the treatment agreement as well as identifying individuals obtaining controlled substances from multiple prescribers, and patients who may be at increased risk for overdose[9-11,36,42].

If the patient's progress is unsatisfactory, the clinician must decide whether to revise or augment the treatment plan, whether other treatment modalities should be added to or substituted for the opioid therapy, or whether a different approach—possibly involving referral to a pain specialist or other health professional—should be employed[19-21,42-43].

Evidence of misuse of prescribed opioids demands prompt evaluation by the clinician, including assessment for opioid use disorder or referral to a substance use disorder treatment specialist for such assessment, and arranging for evidence-based treatment of opioid use disorder if present. Patient behaviors that require such intervention typically involve recurrent early requests for refills, multiple reports of lost or stolen prescriptions, obtaining controlled medications from multiple sources without the clinician's knowledge, intoxication or impairment (either observed or reported), and pressuring or threatening behaviors[11].

When a drug test shows the presence of illicit drugs or drugs not prescribed by a clinician, this requires action on the part of the clinician. Some aberrant behaviors are more closely associated with substance use disorder. Of greatest concern is a pattern of behavior that suggests substance use disorder, such as unsanctioned dose escalations, deteriorating function, and failure to comply with the treatment plan[44].

Documented drug diversion or prescription forgery, and abusive or assaultive behaviors require a firm, immediate response[10-11,22,28], which may include properly discharging a patient from the clinician's practice. Indeed, failure to respond can place the patient and others at significant risk of adverse consequences, including accidental overdose, suicide attempts, arrests and incarceration, or even death[11,45-47].

Consultation and Referral

It is important to consider referral to an interdisciplinary pain management program which includes modalities such as interventional pain management, physical and occupational therapy, acupuncture, or other non-pharmacologic therapies to avoid unnecessary reliance on opioids as the sole therapy for chronic or complex pain issues.

Specialty consultation should be considered if diagnosis and/or treatment for the condition manifesting as pain is outside the scope of the clinician's comfort with dosing requirements. Opioid dose level, in and of itself, does not indicate a referral. However, there is some risk associated with higher doses, and therefore, that may be an indication for consultation, depending on the clinician's training, resources and comfort level. The treating clinician, if possible, should seek a consultation with, or refer the patient to a pain, psychiatric, addiction or mental health specialist as needed.

Clinicians should be aware of treatment options for opioid use disorder and addiction (including those available in licensed opioid treatment programs [OTPs]) and those offered by an appropriately credentialed and experienced clinician through office-based opioid treatment [OBOT]), so as to make appropriate referrals when needed[11,17,21,23].

Discontinuing Opioid Therapy

Throughout the course of opioid therapy, the clinician and patient should regularly weigh the potential benefits and risks of continued treatment and determine whether such treatment remains appropriate[28].

If opioid therapy is continued, the treatment plan may need to be adjusted to reflect the patient's changing physical status and needs, as well as to support safe and appropriate medication use[10-11].

Discontinuing or tapering of opioid therapy may be required for many reasons, and ideally, clinicians will have an end strategy for patients receiving opioids at the outset of treatment. Reasons for discontinuing opioid therapy include resolution of the underlying painful condition, emergence of intolerable side effects, inadequate analgesic effect, failure to improve the patient's quality of life despite reasonable titration, failure to achieve expected pain relief or functional improvement, failure to comply with the treatment agreement, or significant aberrant medication use, including signs of addiction. Additionally, clinicians should not continue opioid treatment unless the patient has received a benefit, including demonstrated functional improvement.

If opioid therapy is discontinued, the patient who has become physically dependent should be provided a safely structured tapering regimen. Withdrawal can be managed either by the prescribing clinician or by referring the patient to an addiction specialist[43]. The termination of opioid therapy should not mark the end of treatment, which should continue with other modalities, either through direct care or referral to other health care specialists, as appropriate[9-11].

Discontinuing opioids is not an easy process for some patients; therefore, a referral may be needed as clinicians have an obligation to provide transition therapy in order to minimize adverse outcomes.

Medical Records

Every clinician who treats patients for chronic pain must maintain accurate and complete medical records. Information that should appear in the medical record includes the following:[10, 11,22,25-26]

- Copies of the signed informed consent and treatment agreement.
- The patient's medical history.
- Results of the physical examination and all laboratory tests.
- Results of the risk assessment, including results of any screening instruments used.
- A description of the treatments provided, including all medications prescribed or administered (including the date, type, dose and quantity).
- Instructions to the patient, including discussions of risks and benefits with the patient and any significant others.
- Results of ongoing monitoring of patient progress (or lack of progress) in terms of pain management and functional improvement.
- Notes on evaluations by and consultations with specialists.
- Results of queries to the state PDMP.
- Any other information used to support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors[9-11,16,22,27,48]. These may include actual copies of, or references to, medical records of past hospitalizations or treatments by other providers.
- Authorization for release of information to other treatment providers.

The medical record must include all prescription orders for opioid analgesics and other controlled substances, whether written or telephoned. In addition, written instructions for the use of all medications should be given to the patient and documented in the record[13]. The name, telephone number, and address of the patient's primary pharmacy should also be recorded to facilitate contact as needed[11]. Records should be up-to-date and maintained in an accessible manner so as to be readily available for review[13].

Compliance with Controlled Substance Laws and Regulations

To prescribe, dispense or administer controlled substances, the clinician must be registered with the DEA, licensed by the state in which he or she practices, and comply with applicable federal and state regulations[13].

Clinicians are referred to the *Physicians' Manual of the U.S. Drug Enforcement Administration* (and any relevant documents issued by the state medical Board) for specific rules and regulations governing the use of controlled substances. Additional resources are available on the DEA's website (at www.deadiversion.usdoj.gov), as well as from (any relevant documents issued by the state medical board).

Section 4 – CONCLUSION

The goal of this Model Policy is to provide state medical and osteopathic boards with an updated guideline for assessing a clinician's management of pain, so as to determine whether opioid analgesics are used in a manner that is both medically appropriate and in compliance with applicable state and federal laws and regulations. The appropriate management of pain, particularly as related to the prescribing of opioid analgesics may include the following:

- **Adequate attention to initial assessment to determine if opioids are clinically indicated and to determine risks associated with their use in a particular individual with pain:** Not unlike many drugs used in medicine today, there are significant risks associated with opioids and therefore benefits must outweigh the risks.

- **Adequate monitoring during the use of potentially abusable medications:** Opioids may be associated with substance use disorder and other dysfunctional behavioral problems, and some patients may benefit from opioid dose reductons or tapering or weaning off the opioid.

- **Adequate attention to patient education and informed consent:** The decision to begin opioid therapy for chronic pain is a shared decision of the clinician and patient after a discussion of the risks and a clear understanding that the clinical basis for the use of these medications for chronic pain is limited, that some pain may worsen with opioids, and taking opioids with other substances (such as benzodiazpines, alcohol, cannabis, or other central nervous system depressants) or certain conditions (e.g., sleep apnea, mental illness, pre-existing substance use disorder) may increase risk.

- **Justified dose escalation with adequate attention to risks or alternative treatments:** Risks associated with opioids increase with escalating doses as well as in the setting of other comorbidities (i.e. mental illness, respiratory disorders, pre-existing substance use disorder and sleep apnea) and with concurrent use with respiratory depressants such as benzodiazepines or alcohol.

- **Avoid excessive reliance on opioids, particularly high dose opioids for chronic pain management:** It is strongly recommended that prescibers be prepared for risk

management with opioids in advance of prescribing, and should use opioid therapy for chronic pain that is not cancer-related, or part of palliative care or end-of-life care, only when non-opioid and non-pharmacological options have not been effective. Maintain opioid dosage as low as possible and continue only if clear and objective outcomes are being met.

- **Utilization of available tools for risk mitigations:** The state prescription drug monitoring program should be checked in advance of prescribing opioids and should be utilized for ongoing monitoring.

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WORKGROUP ON FSMB'S MODEL POLICY ON THE USE OF OPIOID ANALGESICS IN THE TREATMENT OF CHRONIC PAIN

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EXHIBIT 31

EXHIBIT 31

this rule effective within less than 30 days.

List of Subjects in 14 CFR Part 91

Air traffic control, Aircraft, Airmen, Airports, Aviation safety.

The Amendment

■ In consideration of the foregoing, the Federal Aviation Administration amends Chapter I of Title 14, Code of Federal Regulations, as follows:

PART 91—GENERAL OPERATING AND FLIGHT RULES

■ 1. The authority citation for part 91 continues to read as follows:

Authority: 49 U.S.C. 106(g), 1155, 40103, 40113, 40120, 44101, 44111, 44701, 44704, 44709, 44711, 44712, 44715, 44716, 44717, 44722, 46306, 46315, 46316, 46504, 46506–46507, 47122, 47508, 47528–47531, articles 12 and 29 of the Convention on International Civil Aviation (61 Stat. 1180).

■ 2. Amend Appendix D to Part 91 by revising section 1 introductory text to read as follows:

Appendix D to Part 91—Airports/ Locations: Special Operating Restrictions

Section 1. Locations at which the requirements of § 91.215(b)(2) and § 91.225(d)(2) apply. The requirements of §§ 91.215(b)(2) and 91.225(d)(2) apply below 10,000 feet MSL within a 30-nautical-mile radius of each location in the following list.

* * * * *

Issued in Washington, DC, on October 1, 2010.

Pamela Hamilton-Powell,

Director, Office of Rulemaking.

[FR Doc. 2010–25102 Filed 10–5–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

21 CFR Part 1306

[Docket No. DEA–339S]

Role of Authorized Agents in Communicating Controlled Substance Prescriptions to Pharmacies

AGENCY: Drug Enforcement Administration, Department of Justice.

ACTION: Statement of policy.

SUMMARY: The Drug Enforcement Administration (DEA) is issuing this statement of policy to provide guidance under existing law regarding the proper role of a duly authorized agent of a DEA-registered individual practitioner in connection with the communication of a controlled substance prescription to a pharmacy.

FOR FURTHER INFORMATION CONTACT: Mark W. Caverly, Chief, Liaison and Policy Section, Office of Diversion Control, Drug Enforcement Administration, 8701 Morrissette Drive, Springfield, VA 22152; telephone (202) 307–7297.

SUPPLEMENTARY INFORMATION:

Legal Authority

DEA implements and enforces Titles II and III of the Comprehensive Drug Abuse Prevention and Control Act of 1970, often referred to as the Controlled Substances Act (CSA) and the Controlled Substances Import and Export Act (CSIEA) (21 U.S.C. 801–971), as amended. DEA publishes the implementing regulations for these statutes in title 21 of the Code of Federal Regulations (CFR), parts 1300 through 1321. These regulations are designed to ensure that there is a sufficient supply of controlled substances for legitimate medical, scientific, research, and industrial purposes and to deter the diversion of controlled substances to illegal purposes. Controlled substances are drugs that have a potential for abuse and dependence; these include substances classified as opioids, stimulants, depressants, hallucinogens, anabolic steroids, and drugs that are immediate precursors of these classes of substances. The CSA mandates that DEA establish a closed system of control for manufacturing, distributing, and dispensing controlled substances. Any person who manufactures, distributes, dispenses, imports, exports, or conducts research or chemical analysis with controlled substances must register with DEA (unless exempt) and comply with the applicable requirements for the activity.

Background

Under longstanding Federal law, controlled substances are strictly regulated to ensure a sufficient supply for legitimate medical, scientific, research, and industrial purposes and to deter diversion of controlled substances to illegal purposes. The substances are regulated because of their potential for abuse and likelihood to cause dependence when abused and because of their serious and potentially unsafe nature if not used under proper circumstances. To minimize the likelihood that pharmaceutical controlled substances would be diverted into illicit channels, Congress established under the CSA a closed system of drug distribution for legitimate handlers of controlled substances. The foundation of this system is the concept of registration. The only persons who may lawfully manufacture, distribute and dispense controlled substances under the CSA are those who have obtained a DEA registration authorizing them to do so. 21 U.S.C. 822. Thus, the prescribing of controlled substances may be carried out only by those practitioners who have obtained a DEA registration authorizing such activity.

To be eligible for a DEA registration as a practitioner under the CSA, one must be a physician, dentist, veterinarian, hospital, or other person licensed, registered, or otherwise permitted by the United States or the State in which he or she practices to dispense controlled substances in the course of professional practice. 21 U.S.C. 802(21), 823(f). Thus, State licensure to prescribe controlled substances is generally a prerequisite to obtaining a DEA registration to do so. The term "individual practitioner" excludes institutions such as hospitals, which are themselves DEA registrants and are permitted to administer and dispense, but not prescribe, controlled substances under their registration. 21 CFR 1300.01(b)(17).

By longstanding statutory requirement, a valid prescription issued by a DEA-registered practitioner is required for dispensing a controlled substance. To be effective (*i.e.*, valid), a prescription for a controlled substance must be issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice. *United States* v. *Moore*, 423 U.S. 122 (1975); 21 CFR 1306.04(a). Thus, the practitioner must determine that a prescription for a controlled substance is for a legitimate medical purpose. While the core responsibilities pertaining to prescribing controlled substances may not be delegated to anyone else, an individual practitioner may authorize an agent to perform a limited role in communicating such prescriptions to a pharmacy in order to make the prescription process more efficient. Nonetheless, it is important to understand that any agency relationship must also preserve the requirement that medical determinations to prescribe controlled substances be made by a practitioner only, not by an agent. Accordingly, this statement of policy outlines DEA's existing statutory and regulatory requirements as to the proper role of duly authorized agents of individual practitioners. DEA anticipates the utilization of electronic prescribing by practitioners for

controlled substance prescriptions will reduce the role of agents over time.

Medical Determination of Need for a Controlled Substance Prescription Cannot Be Delegated

DEA regulations state: "A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription." 21 CFR 1306.04(a). Accordingly, the practitioner must determine that a prescription for a controlled substance is for a legitimate medical purpose. This determination is the sole responsibility of the practitioner and may not be delegated.

Elements of a Valid Prescription Must be Specified by the Practitioner and Cannot be Delegated

Controlled substance prescriptions are orders for medication to be dispensed to an ultimate user and are required to contain specific information including: Patient name, address, drug name and strength, quantity prescribed, directions for use, and the name, address and DEA number of the issuing practitioner. 21 CFR 1306.05(a). All prescriptions for controlled substances must be dated as of, and signed on, the day when issued. Paper prescriptions must be manually signed by the issuing practitioner in the same manner that the practitioner would sign a check or other legal document (21 CFR 1306.05(d)); electronic prescriptions for controlled substances must be signed in accordance with DEA regulations (21 CFR 1306.05(e), 21 CFR 1311.140).

The regulations provide that "[a] prescription may be prepared by the secretary or agent for the signature of a practitioner, but the prescribing practitioner is responsible in case the prescription does not conform in all essential respects to the law and regulations." 21 CFR 1306.05(f). Accordingly, an authorized agent may prepare a controlled substance prescription only based on the instructions of the prescribing practitioner as to the required elements of a valid prescription and then provide the prescription to the practitioner to review. The authorized agent does not have the authority to make medical determinations. The practitioner must personally sign the prescription, whether manually or electronically. The prescribing practitioner cannot delegate his or her signature authority.

Role of Agent Under the CSA

As discussed above, the CSA does not permit a prescribing practitioner to delegate to an agent or any other person the practitioner's authority to issue a prescription for a controlled substance. A practitioner acting in the usual course of his or her professional practice must determine that there is a legitimate medical purpose for a controlled substance prescription; an agent may not make this determination. Even though the CSA established a closed system in which all persons in the distribution chain are required to be registered and are held accountable for every controlled substance transaction, Congress recognized a role for agents under the Act. The CSA exempts agents of registrants, including practitioners, from the requirement of registration. 21 U.S.C. 822(c)(1). The statute defines an "agent" as "an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser. * * *." 21 U.S.C. 802(3). Likewise, DEA regulations implementing the CSA specifically permit a practitioner to use an authorized agent to perform certain ministerial acts in connection with communicating prescription information to a pharmacy. The common means to communicate a prescription to a pharmacy include hand delivery, facsimile, phone call, or an electronic transmission. As explained below, the proper role of an agent depends upon the schedule of the controlled substance prescribed, the circumstances of the ultimate user, and the method of communication.

Communication by Facsimile or Oral Communication of a Valid Prescription for a Schedule III, IV, or V Controlled Substance May be Delegated to an Authorized Agent

The CSA provides that a pharmacy may dispense Schedule III and IV controlled substances pursuant to a "written or oral prescription." 21 U.S.C. 829(b). DEA regulations further specify that a pharmacist may dispense a Schedule III, IV, or V controlled substance pursuant to "either a paper prescription signed by a practitioner [or] a facsimile of a signed paper prescription transmitted by the practitioner or the practitioner's agent to the pharmacy, * * *." 21 CFR 1306.21(a). Accordingly, an authorized agent may transmit such a practitioner-signed paper prescription via facsimile to the pharmacy on behalf of the practitioner.

Controlled substances in Schedules III, IV and V may also be dispensed by a pharmacy pursuant to "an oral prescription made by an individual practitioner and promptly reduced to writing by the pharmacist containing all information required [for a valid prescription], except for the signature of the practitioner." 21 CFR 1306.21(a). Under DEA regulations, an authorized agent may orally communicate such a prescription to a pharmacist. 21 CFR 1306.03(b). Where the pharmacist has reason to believe that a prescription has been communicated by an agent, the pharmacist, in accordance with his or her responsibility for proper dispensing of controlled substances, may have a duty to inquire into the legitimacy of the prescription. The particular circumstances will dictate the appropriate level of inquiry by the pharmacist. As noted above, the practitioner remains responsible for ensuring that the prescription conforms to the law and regulations, and the practitioner cannot delegate to an agent the authority to make a medical determination of need for a controlled substance prescription.

Generally, a Valid Schedule II Controlled Substance Prescription May Not be Communicated by Facsimile

Because Schedule II controlled substances have the highest potential for abuse and the greatest likelihood of dependence among the pharmaceutical controlled substances (those in Schedules II–V), the CSA controls on Schedule II drugs are the most restrictive. The CSA requires that a Schedule II controlled substance be dispensed by a pharmacy only pursuant to a written prescription, except in emergency situations, and prohibits Schedule II prescriptions from being refilled. 21 U.S.C. 829(a). Thus, in most cases, a pharmacist must receive the original, manually signed paper prescription or an electronic prescription prior to dispensing a Schedule II controlled substance. 21 CFR 1306.11(a).

A Valid Schedule II Controlled Substance Prescription For a Person in a Hospice or Long Term Care Facility (LTCF) May be Communicated by Facsimile and That Communication May be Delegated to an Authorized Agent

DEA regulations specify two exceptions whereby a Schedule II controlled substance prescription sent by facsimile may serve as the original written prescription. A practitioner or a practitioner's authorized agent may transmit a valid Schedule II controlled

substance prescription to a pharmacy via facsimile for: (1) Patients enrolled in a hospice care program certified and/or paid for by Medicare under Title XVIII or hospice programs which are licensed by the State (21 CFR 1306.11(g)); and (2) residents of LTCFs (21 CFR 1306.11(f)). The facsimile serves as the original written prescription and must be maintained by the pharmacy as such. An authorized agent of the prescribing practitioner may transmit the practitioner-signed prescription by facsimile on behalf of the practitioner.

Emergency Oral Communication of a Valid Schedule II Controlled Substance Prescription May Not be Delegated to an Authorized Agent

The CSA contains an exception that allows a practitioner to issue oral prescriptions for Schedule II controlled substances in an emergency. 21 U.S.C. 829(a). An emergency for this purpose is defined by the Food and Drug Administration in 21 CFR 290.10. DEA regulations limit such an emergency oral prescription to the quantity necessary to treat the patient during the emergency period and require that it be followed up within 7 days by a practitioner-signed, written prescription to the dispensing pharmacy. 21 CFR 1306.11(d). Moreover, oral emergency prescriptions must immediately be reduced to writing by the pharmacist and must contain all the information ordinarily required in a prescription, except for the signature of the prescribing individual practitioner. If the prescribing individual practitioner is not known to the pharmacist, the pharmacist must make a reasonable effort to determine that the oral authorization came from a registered individual practitioner, which may include a call back to the prescribing individual practitioner and/or other good faith efforts to ensure the practitioner's identity. 21 CFR 1306.11(d). Because the more specific requirement that the emergency Schedule II oral authorization must be from a registered individual practitioner (21 CFR 1306.11(d)) supersedes the general rule that an employee or agent of the individual practitioner may communicate prescriptions to a pharmacist (21 CFR 1306.03(b)), the prescribing individual practitioner must personally communicate the emergency oral prescription to the pharmacist. An agent may not call in an oral prescription for a Schedule II controlled substance on behalf of a practitioner even in an emergency circumstance.

Pharmacist Dispensing a Controlled Substance Prescription Has a Duty To Fill Only Valid Prescriptions

Regardless of the method of transmission of a controlled substance prescription—by hand delivery, facsimile, phone call or electronically—DEA regulations make it clear that the legal responsibility for issuing a valid prescription that "conform[s] in all essential respects to the law and regulations" rests upon the prescribing practitioner. As noted, however, a pharmacist has a corresponding responsibility for the proper prescribing and dispensing of controlled substances. 21 CFR 1306.04(a). Further, "A corresponding liability rests upon the pharmacist, including a pharmacist employed by a central fill pharmacy, who fills a prescription not prepared in the form prescribed by DEA regulations." 21 CFR 1306.05(f). A pharmacist must carefully review all purported controlled substance prescriptions to ensure that the prescription meets all of the legal requirements for a valid prescription. The pharmacist has a duty to inquire further as to any question surrounding the satisfaction of any or all of the legal requirements for a valid prescription depending upon the particular circumstances, including the requirement that the prescription be issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice. The pharmacist must be satisfied that the prescription is consistent with the CSA and DEA regulations before dispensing a controlled substance to the ultimate user.

Summary of the Acts That an Agent May Take in Connection With Controlled Substance Prescriptions

1. An authorized agent of an individual practitioner may prepare a written prescription for the signature of the practitioner, provided that the practitioner, in the usual course of professional practice, has determined that there is a legitimate medical purpose for the prescription and has specified to the agent the required elements of the prescription. 21 CFR 1306.04(a); 1306.05(a), (f).

2. Where a DEA-registered individual practitioner has made a valid oral prescription for a controlled substance in Schedules III–V by conveying all the required prescription information to the practitioner's authorized agent, that agent may telephone the pharmacy and convey that prescription information to the pharmacist. 21 CFR 1306.03(b), 1306.21(a).

3. In those situations in which an individual practitioner has issued a valid written prescription for a controlled substance, and the regulations permit the prescription to be transmitted by facsimile to a pharmacy (as set forth in 21 CFR 1306.11(a), 1306.11(f), 1306.11(g), and 1306.21(a)), the practitioner's agent may transmit the practitioner-signed prescription to the pharmacy by facsimile.

Who Is an Agent of an Individual Practitioner for the Purpose of Communicating a Prescription for a Controlled Substance

The CSA defines an "agent" as "an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser. * * *" 21 U.S.C. 802(3). Under the CSA, the term "dispense" includes "prescribing." 21 U.S.C. 802(10). Establishment of an agency relationship, consistent with the CSA, is guided by general precepts of the common law of agency. For the purposes of explaining the law of agency as it relates to the CSA, it is appropriate to refer to and consider as generally applicable the Restatement of Agency (Restatement) which provides:

> Agency is the fiduciary relationship that arises when one person (a "principal") manifests assent to another person (an "agent") that the agent shall act on the principal's behalf and subject to the principal's control, and the agent manifests assent or otherwise consents so to act.
>
> Restatement (Third) of Agency § 1.01 (2006).

The Restatement is useful in evaluating whether, for CSA purposes, a valid agency relationship exists between a prescribing practitioner and another person for the purpose of communicating a prescription for a controlled substance to a pharmacy. The Restatement requires that the principal (in this context, the DEA-registered individual practitioner) "manifests assent" for a certain person to act on his or her behalf. This is consistent with the CSA and its registration-based system of accountability. Where non-DEA registrants communicate a prescription for a controlled substance on behalf of a registrant, it is important that such persons be clearly identified and their activities be subject to evaluation to ensure they do not exceed the bounds of the agency relationship and the legal limits of an agent's role under the CSA. Because the individual practitioner remains responsible for ensuring that all prescriptions issued pursuant to his or her DEA registration comply in all respects with the CSA and DEA regulations, it is important that the practitioner decide who may act as his

or her agent. This is also consistent with the CSA definition that an agent is "an authorized person who acts on behalf of or at the direction of" the prescribing individual practitioner. 21 U.S.C. 802(3).

In addition to requiring that the principal (*i.e.*, individual prescribing practitioner) "manifests assent" to having a particular person act as his or her agent, and that the agent reciprocate by manifesting assent to serve as such, the Restatement also requires that the agent acts "subject to the principal's control." In an employment situation, an individual practitioner may establish the duties of his or her employees and is responsible for monitoring their activities. Absent an employer-employee relationship, a practitioner will generally have less control over other persons that he or she may designate as his or her agent(s). Prior to designating an agent, a practitioner may wish to consider the degree of control that the registrant may exercise over the proposed agent, the proposed agent's licensure, level of training and experience, and other such factors to determine whether the person would be an appropriate agent and to ensure that the agent will not engage in activities that exceed the scope of the agency relationship. Absent affirmative actions by the practitioner and the proposed agent, a valid agency relationship generally will not exist outside an employer-employee relationship.

By requiring that an agency relationship is created when (1) the principal manifests assent that a particular person shall act (i) on his or her behalf and (ii) subject to his or her control, and (2) the agent manifests assent so to act, the Restatement definition of "agency" is consistent with the CSA's definition of "agent" as "an authorized person who acts on behalf of or at the direction of" the prescribing practitioner. 21 U.S.C. 802(3). An agent may not legally perform duties that must be personally performed by the individual practitioner. The practitioner may assign only those duties which may be carried out by an agent.

DEA notes that in a 2001 notice and solicitation of information on the potential use of automated dispensing systems to prevent the accumulation of surplus controlled substances at LTCFs, DEA briefly discussed the role of nurses in the narrow setting of LTCFs outside of an employer-employee relationship and where no affirmative actions established an agency relationship between the individual practitioner and the LTCF nurse. 66 FR 20833, 20834 (April 25, 2001). This incidental example and other informal discussions have resulted in the need for this published articulation of what existing law allows and what affirmative actions may be required to establish a valid agency relationship for purposes of an authorized agent to communicate controlled substance prescriptions to pharmacies, particularly in settings where there is no employer-employee relationship. DEA regulations on the role of authorized agents in communicating controlled substance prescriptions to pharmacies generally have not changed.

This policy statement outlines the proper role of agents in those situations where an individual practitioner and an individual agent (including but not limited to an LTCF nurse) have taken affirmative steps to establish a valid agency relationship for those aspects of the CSA that may be appropriately executed by an authorized agent under Federal law. As such, DEA is hereby outlining a suggested mechanism to establish a valid agency relationship as well as explaining the appropriate roles an authorized agent may play regardless of the setting. This statement of policy is intended to provide general guidance on establishment of a valid agency relationship between an individual practitioner and an identified individual. DEA wishes to emphasize that, regardless of the setting, it is the practitioner's sole decision as to whether or not to designate an agent to act on his or her behalf and subject to his or her control. To be consistent with the purpose of the CSA to implement a "closed system" of distribution and for DEA to enforce this framework, an agency relationship between a registered individual practitioner and an identified agent for the purposes of communicating controlled substance prescriptions must be explicit and transparent. DEA believes its existing regulations are adequate in addressing the role of an authorized agent but will analyze whether additional federal rulemaking or guidance is needed beyond this statement to establish the necessary explicit and transparent nature of an authorized agency relationship, particularly when outside an employer-employee relationship.

Written Authorization of an Agent Recommended—Sample Agency Agreement

Due to the legal responsibilities of practitioners and pharmacists under the CSA and the potential harm to the public from inappropriate and unlawful prescribing and dispensing of controlled substances, violations of the law are subject to criminal, civil, and administrative sanctions. DEA believes it is in the best interests of the practitioner, the agent, and the dispensing pharmacist that the designation of those persons authorized to act on behalf of the practitioner and the scope of any such authorization be reduced to writing.

DEA provides below an example of a written agreement that would properly confer authority to an agent to act on behalf of an individual practitioner with regard to controlled substance prescriptions. Individual practitioners may choose to designate and authorize one or more persons at one or more locations within or outside their practice to act as their agent. Likewise, an individual may act as an authorized agent for multiple individual practitioners depending upon the circumstances. A practitioner may or may not wish to delegate all of these types of authorized communications to a particular agent and may tailor the agreement accordingly. The agreement should be clear that the agent may not further delegate the outlined responsibilities.

Designating Agent of Practitioner For Communicating Controlled Substance Prescriptions to Pharmacies

_____
(Name of registered individual practitioner)

_____
(Address as it appears on certificate of registration)

_____
(DEA registration number)

I, _____ (name of registrant), the undersigned, who is authorized to dispense (including prescribe) controlled substances in Schedules II, III, IV, and V under the Controlled Substances Act, hereby authorize_____ (name of agent), to act as my agent only for the following limited purposes:

1. To prepare, for my signature, written prescriptions for controlled substances in those instances where I have expressly directed the agent to do so and where I have specified to the agent the required elements of the prescription (set forth in 21 CFR 1306.05).

2. To convey to a pharmacist by telephone oral prescriptions for controlled substances in Schedules III, IV, and V in those instances where I have expressly directed the agent to do so and where I have specified to the agent the required elements of the prescription (set forth in 21 CFR 1306.05).

3. To transmit by facsimile to a pharmacy prescriptions for controlled

substances in those instances where I have expressly directed the agent to do so and where I have specified to the agent the required elements of the prescription (set forth in 21 CFR 1306.05) and I have signed the prescription.

This authorization is not subject to further delegation to other persons. Both the undersigned DEA-registered individual practitioner and the undersigned agent understand and agree that the practitioner is solely responsible for making all medical determinations relating to prescriptions for controlled substances communicated by the agent pursuant to this agreement, and for ensuring that all such prescriptions conform in all other essential respects to the law and regulations.

The undersigned agent understands he or she does not have authority to make any medical determinations. The undersigned DEA-registered prescribing practitioner further understands that the prescribing practitioner must personally communicate all Schedule II emergency oral prescriptions to the pharmacist. Both the undersigned practitioner and agent understand that the agent may not call in an emergency oral prescription for a Schedule II controlled substance on behalf of the practitioner.

This agency agreement shall be terminated immediately if and when any of the following occur:

1. The undersigned practitioner no longer possesses the active DEA registration specified in this agreement.
2. The undersigned agent is no longer employed in the manner described in this agreement.
3. The practitioner or the agent revokes this agency agreement by completing the revocation section at the end of this document or by executing a written document that is substantially similar to the revocation section at the end of this document.

_____
(Signature of practitioner)

I, _____ (name of agent), hereby affirm that I am the person named herein as agent and that the signature affixed hereto is my signature. I further affirm that I am a _____ (title), licensed in the State of _____, (where applicable) and (if applicable) am employed by/under contract with _____ (name of employer or contracting entity). I agree to abide by all the terms of this agreement and to comply with all applicable laws and regulations relating to controlled substances.

_____
(Signature of agent)

_____
(State license number of agent where applicable)

_____
(Name of employer/contracting entity where applicable)

_____
(Address of employer/contracting entity where applicable)

Witnesses:

1. _____
2. _____

Signed and dated on the _____ day of _____ (month) _____, (year), at _____.

Revocation

The foregoing agency agreement is hereby revoked by the undersigned. The agent is no longer authorized to communicate Schedule II, III, IV and V controlled substance prescriptions to a pharmacy on my behalf. A copy of this revocation has been given to the agent this same day.

_____
(Signature of registered practitioner revoking power)

Witnesses:

1. _____
2. _____

Signed and dated on the _____ day of _____(month)_____, (year), at _____.

DEA recommends that the original signed agency agreement be kept by the practitioner during the term of the agency relationship and for a reasonable period after termination or revocation. DEA requires that inventory and other records be kept for at least two years (21 U.S.C. 827(b), 21 U.S.C. 828(c), 21 CFR 1304.04). This is simply a suggested time period for retention of agency agreements and is not required by DEA. A signed copy should also be provided to the practitioner's designated agent, the agent's employer (if other than the practitioner), and any pharmacies that regularly receive communications from the agent pursuant to the agreement. Providing a copy to pharmacies likely to receive prescriptions from the agent on the practitioner's behalf may assist those pharmacies with their corresponding responsibility regarding the dispensing of controlled substances. It is important to reiterate that a pharmacist always has a corresponding responsibility to ensure that a controlled substance prescription conforms with the law and regulations, including the requirement that the prescription be issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice, and a corresponding liability if a prescription is not prepared or dispensed in a manner consistent with the CSA or DEA regulations. Even where the pharmacist has a copy of an agency agreement, the pharmacist may also have a duty to inquire further depending upon the particular circumstances. Because the agency agreement may be revoked at any time by the practitioner or by the agent, the party terminating the agreement should notify the other party immediately upon termination. The practitioner should notify those pharmacies that were originally made aware of the agency agreement of the termination of that agreement. In most circumstances where an agent changes employment, the agreement should be revoked.

Dated: October 1, 2010.

Joseph T. Rannazzisi,

Deputy Assistant Administrator, Office of Diversion Control.

[FR Doc. 2010–25136 Filed 10–5–10; 8:45 am]

BILLING CODE 4410–09–P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 323

[Docket ID DOD–2010–OS–0139]

Privacy Act of 1974; Implementation

AGENCY: Defense Logistics Agency; DoD.

ACTION: Final rule; request for comments.

SUMMARY: The Defense Logistics Agency is revising two exemption rules. The exemption rule for S100.10 entitled "Whistleblower Complaint and Investigative Files" is being deleted in its entirety and the exemption rule system identifier for the "Incident Investigation/Police Inquiry Files" system of records is being revised.

DATES: The rule will be effective on December 6, 2010, unless comments are received that would result in a contrary determination.

Comments will be accepted on or before December 6, 2010.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Federal Docket Management System Office, 1160 Defense Pentagon, Room 3C843, Washington, DC 20301–1160.

Instructions: All submissions received must include the agency name, docket number and title for this **Federal Register** document. The general policy

EXHIBIT 32

EXHIBIT 32

JAYLEEN CHEN, M.D.

[redacted]

Employment

Thrive Wellness of Reno, Reno, Nevada — June 2021 - Present
General/Child and Adolescent Psychiatrist, Medical Director

Willow Springs Center, Reno, Nevada — August 2015 - Present
Child and Adolescent Psychiatrist

True North Treatment Center, Reno, Nevada — April 2016 – Feb 2020
General/Child and Adolescent Psychiatrist, Medical Director

Education

University of Nevada-School of Medicine (UNSOM) — July 2013 - June 2015
Child and Adolescent Psychiatry Fellowship

University of Nevada-School of Medicine (UNSOM) — July 2010 - June 2013
Psychiatry Residency

University of Nevada-School of Medicine — August 2006 - May 2010
Medical Doctor

University of Nevada-Reno — August 2001 - June 2005
B.S. Biology with High Distinction, Minor in Chemistry

Board Certification

Psychiatry #71024 — September 2016
Child and Adolescent Psychiatry #10146 — September 2017

Honors and Awards

- Arnold P. Gold Foundation Humanism and Excellence in Teaching Award, UNSOM, 2012
- UNSOM Resident Teaching Honor Roll (two-time recipient), 2010 & 2011
- Richard Blurton Award for Outstanding Student in Psychiatry and Behavioral Sciences, UNSOM, 2010
- Senior Scholar for College of Science, University of Nevada-Reno, 2005
- Dean's Scholar for Biology, University of Nevada-Reno, 2005

Publications

- Meekile N. Mason, M.D. and *Jayleen Chen, M.D.* "Chapter 7: Terminal Illness in Prison." *Correctional Psychiatry*, Volume 2. Currently in editing by Civic Research Institute, Inc. 2012
- Bhakta, A., *Chen, J.,* Larsen, J., Spogen, D. "Aging Athletes," Pepid Program for PDA, <http://www.pepidonline.com/content/content.aspx?url=authorscredentials_rz.htm#spogen> April 2008

Clinical and Teaching Experience

- Collaborating Physician for Psychiatric Physician Assistant, 2023 - Present
- Collaborating Physician for Psychiatric Nurse Practitioner, 2020 - Present
- Preceptor to Psychiatric Nurse Practitioner Students, 2016 - Present
- Psychiatric Medicine Small Group Leader for UNSOM 2nd year Medical Students, 2012 and 2017
- Student Outreach Clinic Volunteer, 2005 - 2007
- Chemistry Tutor, Student Academic Skills Center, University of Nevada-Reno, 2005

Relevant Research Projects

- Spirituality in Medicine, 2009

Conducted a survey assessing the prevalence of spirituality in medicine in Dayton, Nevada at Dr. Robert Chudnow's Geriatric Medicine and Family Practice Clinic

- Developmental Pediatrics, 2009

Under the direction of Lynn Kinman, M.D. Prepared a research paper detailing the "Psychological Effects of Early Childhood Maltreatment," for a local court case deposition

- Rheumatology, 2007

Under the direction of Malin Prupas, M.D. FACP Conducted a randomized study comparing the effect of follow-up phone calls to selected patients receiving intra-articular injections versus those who did not receive a courtesy call

Professional Affiliations and Activities

- Thrive Wellness of Reno – Medical Director, 2022 - Present
- Willow Springs Center – Chief of Staff, 2018 - 2022
- Willow Springs Center – Interim Medical Director, 2018
- True North Treatment Center – Medical Director, 2016 – 2020
- Nevada Psychiatric Association – Member, 2011 - Present
- Nevada Psychiatric Association – Northern Chapter President, 2012 - 2013
- Nevada Psychiatric Association – Northern Chapter Secretary, 2011 - 2012
- American Psychiatric Association – Fellow Member, 2011 - Present
- American Academy of Child and Adolescent Psychiatry – Member, 2009 – Present

Interests

Family and friends, cooking and baking, sports, hiking, and local theater.

EXHIBIT 33

EXHIBIT 33

CERTIFICATE OF CUSTODIAN OF RECORDS OR SANA BEHAVIORAL HOSPITAL

STATE OF NEVADA)
) ss.
COUNTY OF CLARK)

NOW COMES KATHY KERSHAW (*name of custodian of records*), who after being first duly sworn, deposes and says:

1. That I am the CUSTODIAN OF RECORDS (*position or title*) of SANA BEHAVIORAL (*name of company or employer*) and in my capacity as CUSTODIAN OF RECORDS (*position or title*), I am a custodian of the records of SANA BEHAVIORAL (*name of company or employer*).

2. That SANA BEHAVIORAL (*name of company or employer*) is licensed to do business as a HOSPITAL in the State of Nevada.

3. That on the 30TH day of the month of MARCH of the year 2020, I received a request for health care records in connection with the Nevada State Board of Medical Examiners Case No. [redacted], calling for the production of records pertaining to MEDICAL RECORDS.

4. That I have examined the original of those records and have made or caused to be made a true and exact copy of them and the reproduction attached hereto is true and complete.

5. That the original of those records was made at or near the time of the act, event, condition, opinion or diagnosis recited therein by or from information transmitted by a person with knowledge, in the course of a regularly conducted activity of SANA BEHAVIORAL (*name of company or employer*).

Executed on: 3-30-2020 Kathy Kershaw
Date *Signature of Custodian of Records*

SUBSCRIBED AND SWORN to before me this 30TH day of MARCH, 2020.

Lisa Moffett
NOTARY PUBLIC in and for the
County of CLARK, State of Nevada.

LISA MOFFETT
Notary Public, State of Nevada
Appointment No. 18-1744-1
My Appt. Expires Apr 1, 2022

My commission expires: April 1, 2022

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BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **MATTHEW OBIM OKEKE, M.D.,** **Respondent.**	**Case No. 24-22461-2**

FILED
FEB 21 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Sarah A. Bradley, J.D., MBA, Deputy Executive Director and attorney for the IC, having a reasonable basis to believe that Matthew Obim Okeke, M.D., (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active-probation license to practice medicine the State of Nevada (License No. 14957). Respondent was originally licensed by the Board on October 8, 2003.[2]

Treatment of Patient A

2. Patient A[3] was a twenty-six (26) year-old female at the time of the events at issue.

3. Beginning on January 1, 2018, prescribing practitioners in Nevada were required to before issuing an initial prescription for controlled substances listed in Schedules II, III, or IV, or an opioid that is a controlled substance listed in Schedule V, and at least once every ninety (90)

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Bret W. Frey, M.D., Chowdhury H. Ahsan, M.D., PhD., FACC, and Col. Eric D. Wade, USAF (Ret.) (Public Member).

[2] Respondent's original license number issued on October 8, 2003, was 10668. Respondent was issued license number 14957 on September 6, 2013.

[3] Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

days thereafter for the duration of the course of treatment of using the controlled substance, obtain a patient utilization report (Patient Report) regarding the patient from the Prescription Monitoring Program (PMP).

4. The current medications list for Patient A on January 18, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 30 quantity with 1 per day for 15 days only, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, and Xanax .5 mg 60 quantity with 1 per day.

5. The current medications list for Patient A on February 23, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 30 quantity with 1 per day for 15 days only, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

6. The current medications list for Patient A on March 23, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 30 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

7. It should be noted that Patient A's current medication list was changed on March 23, 2018, from what was shown on February 23, 2018, because the limitation for Norco 5-325 mg for just fifteen (15) days only, was removed.

8. The current medications list for Patient A on April 20, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1

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per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

9. It should be noted that Patient A's current medication list was changed on April 20, 2018, from what was shown on March 23, 2018, because the quantity for Norco 5-325 mg was changed from thirty (30) to sixty (60).

10. The current medications list for Patient A on June 25, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

11. The current medications list for Patient A on July 20, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

12. The current medications list for Patient A on August 17, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

13. The current medications list for Patient A on September 17, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1

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per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

14. The current medications list for Patient A on October 15, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

15. The current medications list for Patient A on November 9, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

16. The current medications list for Patient A on December 10, 2018, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

17. It should be noted that Patient A's current medication list was changed on December 10, 2018, from what was shown on November 9, 2018, because the Xanax 1 mg 60 quantity with 1 per day was removed.

18. The current medications list for Patient A on January 9, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

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19. It should be noted that Patient A's current medication list was changed on January 9, 2019, from what was shown on December 10, 2018, because the Xanax 1 mg 60 quantity with 1 per day was added.

20. The current medications list for Patient A on February 5, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

21. The current medications list for Patient A on March 4, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

22. The current medications list for Patient A on April 4, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

23. The current medications list for Patient A on May 2, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

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24. The current medications list for Patient A on May 20, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

25. The current medications list for Patient A on June 26, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

26. The current medications list for Patient A on July 22, 2019, as shown in Respondent's medical records for Patient A, include among other medications, Norco 10-325 mg 30 quantity with 1 per day, Norco 7.5-325 mg 60 quantity with 1 per day, Norco 5-325 mg 60 quantity with 1 per day, Xanax 2 mg 60 quantity with 1 per day, Xanax 1 mg 60 quantity with 1 per day, Xanax .5 mg 60 quantity with 1 per day, Klonopin 1 mg 60 quantity 1 per day, and Klonopin .5 mg 60 quantity 1 per day.

27. The standard of care for prescribing controlled substances is to avoid the use of benzodiazepines (such as clonazepam and alprazolam) with opioids (such as hydrocodone-acetamin, oxycodone-acetaminophen, and tramadol).

28. There is an increased potential for respiratory depression with the use of opioids and benzodiazepines at the same time.

29. Respondent asserts that he has not prescribed opioids to Patient A since September 25, 2013.[4]

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[4] From the records received by the Board Investigator in this matter, it appears that Patient A first began to receive psychiatric care from Respondent on September 9, 2013. Only Respondent's care of Patient A from January 2018 to July 2019 will be addressed in this Complaint.

30. However, Respondent did prescribe Patient A benzodiazepines from January 2018 to July 2019, and Respondent knew or should have known that Patient A was being prescribed opioids by another prescribing provider at that same time.

31. Patient A's Patient Report from the PMP confirms that she was receiving both benzodiazepines and opioids at the same time. Further, the medical records of Patient A reflect the use of both benzodiazepines and opioids at the same time in her "current medications" list as cited above in factual allegations ¶ 4 to 26.

32. It is concerning that multiple types and strengths of benzodiazepines (five (5) different types) and opioids (three (3) different types) are reflected in Patient A's medical records throughout the her treatment timeline with Respondent.

33. Patient A's Patient Report from the PMP does not support that she was actually taking five (5) different benzodiazepines and three (3) different opioids at the same time. Instead, it appears that the multiple types and strengths of benzodiazepines and opioids in Patient A's medical records is a failure by Respondent to ensure that Patient A's medical records correctly reflected what medications she was actually taking at the time of each visit.

34. Patient A's other medications contained in her medical records throughout this time period also appear to be inaccurate showing additional discrepancies such as three (3) different strengths of Adderall each taken once per day, Bactrim DS 800-160 mg being taken by Patient A from January 18, 2018, through July 22, 2019,[5] two (2) different strengths of Ritalin each taken once per day, and two (2) different strengths of Zoloft each taken once per day.

35. The discrepancies noted in factual allegation at ¶ 32 to 34 constitute a failure by Respondent to ensure that Patient A's medical records correctly reflected what medications she was actually taking at the time of each visit.

[5] Bactrim DS 800-160 mg is an antibiotic used to treat infections. Upon information and belief, it is unlikely that Patient A would take an antibiotic for more than a year without a history of infections or other medical issues being noted. Patient A's medical records maintained by Respondent reflect no history of urinary tract infections or other conditions that may warrant the use of an antibiotic. There is a note about Patient A having a urinary tract infection in January 2019 in the records maintained by another health care provider providing care to Patient A during this same time period. However, Respondent's records reflect no such note, just continuing use of antibiotics by Patient A at every visit with Respondent during this time period. Upon information and belief, the reference to Patient A's use of Bactrim DS 800-160 mg form January 18, 2018, to July 22, 2019, is an example of Respondent's failure to maintain clear, legible, accurate, and complete medical records for Patient A.

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36. Upon information and belief, Respondent copied and pasted progress notes from visit to visit for Patient A, which led to a failure to maintain clear, legible, accurate, and complete medical records for Patient A.

37. Upon information and belief, Respondent's care of Patient A showed a lack of diligence in both documentation, review, and management of her medications which fell below the standard of care.

38. In his response to the Board Investigator regarding Patient A, Respondent stated "I check the PMP regularly."

39. If the statement in ¶ 38 was true, Respondent should have been aware of Patient A's concurrent use of benzodiazepines and opioids.

40. However, the PMP records show that Respondent did not conduct a query of Patient A's prescription history in the PMP to obtain her Patient Report at any time from January 2018 to July 2019.

41. The quantities of controlled substances prescribed to Patient A by Respondent did not always match the progress notes in Patient A's medical records.

42. At times, Respondent provided Patient A with prescriptions that were more than a thirty (30) day supply, even though he was seeing her monthly to manage her medications.

43. Respondent was out of the United States from November 8, 2019, to December 8, 2019.

Treatment of Patient B

44. Patient B[6] was a forty-seven (47) year-old male at the time of the events at issue.

45. Respondent wrote a prescription for a Schedule III controlled substance, Suboxone, for Patient B on November 8, 2019.

46. There is no progress note correlating to a visit on November 8, 2019, when Patient B received the prescription from Respondent.

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[6] Patient B's true identity is not disclosed herein to protect his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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47. Upon information and belief, Respondent did not examine Patient B on November 8, 2019, prior to giving him the prescription for the Schedule III controlled substance, which is a violation of the standard of care.

48. The prescription for Patient B was a paper prescription dated November 8, 2019, that contained a signature from Respondent.[7]

49. Respondent was out of the country on November 8, 2019.

50. Respondent stated in his response to the Board investigator that "I have never seen this patient in any setting that I can remember. I did not give him any prescription. I do not have a record of seeing him or treating him."

51. Upon information and belief, Respondent allowed another person in his office to either sign his name to the prescription for Patient B or Respondent pre-signed the prescription for Patient B prior to leaving the country.

52. PMP records show that Respondent did not check Patient B's Patient Report from the PMP until February 2020.

53. If Respondent's statement to the Board investigator as contained in ¶ 50 was true and Patient B was never his patient, it would be a violation of law for Respondent to check Patient B's Patient Report in the PMP in February 2020.

54. PMP records do not show that Respondent conducted queries of Patient B in the PMP prior to prescribing controlled substances to him or every ninety (90) days after prescribing controlled substances to him as required by Nevada law.

55. A review of Patient B's Patient Report from the PMP shows that Patient B was given a refill for Valium too early.

56. Respondent gave Patient B a thirty (30) day supply of Valium (quantity 60, 5 mg) on April 11, 2019, April 24, 2019, and May 9, 2019.

57. According to Patient B's Patient Report from the PMP, all three (3) of these prescriptions, in addition to others, were written by Respondent.

[7] Please note that the prescription provided to Patient B contains a signature that looks very much like Respondent's signature as seen in other medical records in this matter and other Board matters. This is unlike the prescriptions provided to Patients C, D, and E that contain Respondent's handwritten name, but do not look like his signature.

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Treatment of Patient C

58. Patient C[8] was a fifty-three (53) year-old male at the time of the events at issue.

59. Respondent wrote a prescription for Patient C for controlled substances on November 27, 2019.

60. There is no progress note correlating to a visit on November 27, 2019, when Patient C received the prescription from Respondent.

61. Upon information and belief, Respondent did not examine Patient C on November 27, 2019, prior to giving him the prescription which is a violation of the standard of care.

62. The prescription for Patient C was a paper prescription dated November 27, 2019, that contained a signature from Respondent and/or Respondent's handwritten name. [9]

63. Respondent was out of the country on November 27, 2019.

64. Upon information and belief, Respondent allowed another person in his office to either sign his name to the prescription for Patient C or Respondent pre-signed the prescription for Patient C prior to leaving the country.

65. PMP records show that Respondent did not check Patient C's Patient Report from the PMP until February 2020.

66. PMP records do not show that Respondent conducted queries of Patient C in the PMP prior to prescribing controlled substances to him or every ninety (90) days after prescribing controlled substances to him as required by Nevada law.

Treatment of Patient D

67. Patient D[10] was a seventy-four (74) year-old female at the time of the events at issue.

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[8] Patient C's true identity is not disclosed herein to protect his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

[9] The signature for Respondent on this prescription looks different than other signatures for Respondent shown in other documents. It is possible that Respondent's name was simply written on the prescription by another staff member. For example, the signature from Respondent on the paper prescription for Patient B looks different than that on the prescription for Patient C.

[10] Patient D's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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68. Respondent wrote a prescription for Patient D for controlled substances on November 27, 2019.

69. Respondent is referenced in some documents from Sana Behavioral Health (Sana) as the attending physician for Patient D during her stay at Sana.

70. Respondent's name is signed on the Interdisciplinary Team Meeting note dated November 26, 2019.

71. However, Respondent was out of the country on both November 26, 2019, and November 27, 2019.

72. Sana records support that Patient D was actually seen by ML, M.D. and DP, APRN while at Sana.

73. Upon information and belief, Respondent did not examine Patient D on November 27, 2019, prior to giving her the prescription which is a violation of the standard of care.

74. The prescription for Patient D was a paper prescription dated November 27, 2019, that contained a signature from Respondent and/or Respondent's handwritten name.[11]

75. Delegating signatory approval for Patient D for the prescription and/or Patient D's medical records at Sana is a violation of the standard of care.

76. Upon information and belief, Respondent allowed another person in his office to either sign his name to the prescription for Patient D or Respondent pre-signed the prescription for Patient D prior to leaving the country.

77. PMP records do not show that Respondent conducted queries of Patient D in the PMP prior to prescribing controlled substances to her or every ninety (90) days after prescribing controlled substances to her as required by Nevada law.

Treatment of Patient E

78. Patient E[12] was a fifty-five (55) year-old female at the time of the events at issue.

[11] The signature for Respondent on this prescription looks different than other signatures for Respondent shown in other documents. It is possible that Respondent's name was simply written on the prescription by another staff member. For example, the signature from Respondent on the paper prescription for Patient B looks different than that on the prescription for Patient D.

[12] Patient E's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

79. Respondent wrote a prescription for Patient E for Klonopin on November 15, 2019.

80. Respondent is referenced in some documents from Sana as the attending physician for Patient E during her stay at Sana.

81. Upon a review of the Patient Report from the PMP for Patient E, Patient E also received and filled another prescription for Klonopin from DP, APRN on November 15, 2019.

82. Both prescriptions for Patient E are for a quantity of 60, 1 mg tablets for 30 days.

83. Respondent was out of the country on November 15, 2019.

84. Sana records support that Patient E was actually seen by ML, M.D. and DP, APRN while at Sana.

85. Upon information and belief, Respondent did not examine Patient E on November 15, 2019, prior to giving her the prescription which is a violation of the standard of care.

86. The prescription for Patient E was a paper prescription dated November 15, 2019, that contained a signature from Respondent and/or Respondent's handwritten name.[13]

87. Delegating signatory approval for Patient E for the prescription is a violation of the standard of care.

88. Upon information and belief, Respondent allowed another person in his office to either sign his name to the prescription for Patient E or Respondent pre-signed the prescription for Patient E prior to leaving the country.

89. PMP records do not show that Respondent conducted queries of Patient E in the PMP prior to prescribing controlled substances to her or every ninety (90) days after prescribing controlled substances to her as required by Nevada law.

90. In response to the Board investigator regarding Patient C, D, and E, Respondent concedes that he traveled on the days that prescriptions were provided to those patients and stated that "I would guess that they used my name to fill a prescription" and that he "did not authorize the prescription in any way."

[13] The signature for Respondent on this prescription looks different than other signatures for Respondent shown in other documents. It is possible that Respondent's name was simply written on the prescription by another staff member. For example, the signature from Respondent on the paper prescription for Patient B looks different than that on the prescription for Patient E.

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

91. Upon information and belief, Respondent has not reported the use of his prescribing credentials by others to law enforcement and/or the Nevada Board of Pharmacy.

92. Upon information and belief, if Respondent's statement to the Board investigator in ¶ 90 was correct, Respondent would have and/or should have reported that unauthorized prescribing to law enforcement and/or the Nevada Board of Pharmacy.

90. Upon information and belief, Respondent did not complete the required queries of his prescribing history during 2019 (at least one query of his prescribing history every six months) in order to detect unauthorized use of his prescribing credentials by others.

93. Upon information and belief, if Respondent had completed the required queries of his prescribing history in the PMP in 2019, he would have identified any unauthorized use of his prescribing credentials.

COUNTS I–V

NRS 630.301(4) - Malpractice

94. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

95. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

96. NAC 630.040 defines malpractice as "the failure of a physician . . . in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."

97. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A when he prescribed benzodiazepines to her while she was taking opioids at the same time. Further, when he prescribed controlled substances to Patients A through E via paper prescriptions when he 1) was out of the country, 2) failed to check each patients PMP prior to prescribing them controlled substances as required by law, and 3) failed to examine the patients prior to writing them prescriptions for controlled substances.

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9600 Gateway Drive
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(775) 688-2559

98. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNTS VI–X

NRS 630.3062(1)(a) - Failure to Maintain Complete Medical Records

99. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

100. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient" constitute grounds for initiating discipline against a licensee.

101. Respondent failed to maintain complete medical records relating to his care of Patient A by failing to ensure that her medical records were clear, legible, accurate, and complete with regard to the medications that she was taking at each visit.

102. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patients A through E, by failing to completely and correctly document his medical care and treatment for Patients A through E and/or by over-reliance on templated material in the medical records for Patients A through E and/or by over-reliance on copy and paste for his patients' medical records from visit to visit, causing the medical records for Patients A through E to not be timely, legible, accurate, and complete.

103. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNTS XI–XVI

NRS 630.306(1)(b)(3) - Violation of Statutes and Regulations of the Nevada State Board of Pharmacy

104. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

105. NRS 639.23507 requires that a prescribing practitioner before issuing an initial prescription for controlled substances listed in schedule II, III, or IV, or an opioid that is a controlled substance listed in schedule V, and at least once every ninety (90) days thereafter for

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9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

the duration of the course of treatment using the controlled substance, obtain a patient utilization report (Patient Report) regarding the patient from the PMP.

106. Respondent failed to obtain Patient Reports for Patients A through E as required by NRS 639.23507.

107. Respondent also failed to self-query his prescribing history in the PMP as required by Nevada law.

108. This conduct violates NRS 630.306(1)(b)(3).

109. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNTS XVII–XX

NRS 630.3062(1)(h) - Fraudulent, Illegal, Unauthorized, or Otherwise Inappropriate Prescribing of Controlled Substances Listed in Schedule II, III, or IV

110. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

111. By pre-signing paper prescription pads and providing them to office staff and/or other practitioners so that Respondent's name, Nevada State Board of Pharmacy registration number, and Board license number could be used to prescribe medications to Patients B through E while Respondent was out of the country, Respondent engaged in fraudulent, illegal, unauthorized, or otherwise inappropriate prescribing of controlled substances listed in schedule II, III, or IV.

112. This conduct violates NRS 630.3062(1)(h).

113. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNTS XXI–XXIV

NRS 630.306(2)(b)(1) - Engaging in Conduct Which is Intended to Deceive

114. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

/ / /

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Reno, Nevada 89521
(775) 688-2559

115. By stating in writing "I check the PMP regularly" in a written response to the Board's investigator regarding Patient A when records from the PMP show that Respondent never queried Patient A's Patient Report in the PMP, Respondent engaged in deceptive conduct to the Board and/or IC.

116. By stating in writing that he did not prescribe medications and/or authorize other people to prescribe medications to Patients C, D, and E under his name and "I would guess that they used my name to fill a prescription" and that he "did not authorize the prescription in any way," which is not supported by the records in this case, Respondent engaged in deceptive conduct to the Board and/or IC.

117. This conduct violates NRS 630.3062(1)(h).

118. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 21st day of February, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
Deputy Executive Director
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: bradleys@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 21st day of February, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
BRET W. FREY, M.D.
Chairman of the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 22nd day of February, 2024, I served a file-stamped copy of the foregoing **COMPLAINT** and **PATIENT DESIGNATION** via USPS Certified Mail, postage pre-paid, to the following parties:

MATTHEW OBIM OKEKE, M.D.
c/o Liborius Agwara, Esq.
Law Offices of Libo Agwara, Ltd.
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121

Tracking No.: 9171 9690 0935 0241 6158 93

DATED this 22nd day of February, 2024.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **MATTHEW OBIM OKEKE, M.D.** **Respondent.**	**Case No. 24-22461-2** **(FILED UNDER SEAL)**

FILED

FEB 21 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

PATIENT DESIGNATION

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) hereby submits its **PATIENT DESIGNATION** to identify the true and correct identity of the patient(s) referenced in the filed formal Complaint, Case No. 24-35350-1.

1. Patient A's true and correct identity is as follows:

Nam[redacted]
DOB

2. Patient Bs true and correct identity is as follows:

Nam[redacted]
DOB

3. Patient Cs true and correct identity is as follows:

Nam[redacted]
DOB

4. Patient Ds true and correct identity is as follows:

Nam[redacted]
DOB

5. Patient Es true and correct identity is as follows:

Nam[redacted]
DOB

DATED this 21st day of February, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
Deputy Executive Director
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: bradleys@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **MATHEW OBIM OKEKE,** **Respondent.**	**Case No. 24-22461-2**

FILED

MAR 07 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

PROOF OF SERVICE

I, Mercedes Fuentes, Legal Assistant for the Nevada State Board of Medical Examiners, hereby certify that on February 22, 2024, I sent the **COMPLAINT** and **PATIENT DESIGNATION**, as well as required fingerprinting card with instructions to:

MATTHEW OBIM OKEKE, M.D.
c/o Liborius Agwara, Esq.
Law Offices of Libo Agwara, Ltd.
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121

via USPS Certified Mail, tracking no. 9171969009350241615893, and was delivered on February 27, 2024, at 10:56 a.m.. *See* **Exhibit 1**.

DATED this 7th day of March, 2024.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

EXHIBIT 1

EXHIBIT 1

USPS Tracking®

FAQs >

Remove ×

Tracking Number:

9171969009350241615893

Copy Add to Informed Delivery (https://informeddelivery.usps.com/)

Latest Update

Your item was delivered to the front desk, reception area, or mail room at 10:56 am on February 27, 2024 in LAS VEGAS, NV 89121.

Get More Out of USPS Tracking:

USPS Tracking Plus®

Feedback

Delivered
Delivered, Front Desk/Reception/Mail Room
LAS VEGAS, NV 89121
February 27, 2024, 10:56 am

Arrived at USPS Regional Facility
LAS VEGAS NV DISTRIBUTION CENTER
February 26, 2024, 11:05 am

In Transit to Next Facility
February 25, 2024

Arrived at USPS Regional Origin Facility
RENO NV DISTRIBUTION CENTER
February 23, 2024, 12:25 am

Departed Post Office
RENO, NV 89510
February 22, 2024, 3:31 pm

USPS picked up item

RENO, NV 89510
February 22, 2024, 3:02 pm

Hide Tracking History

What Do USPS Tracking Statuses Mean? (https://faq.usps.com/s/article/Where-is-my-package)

Text & Email Updates

Return Receipt Electronic

USPS Tracking Plus®

Product Information

See Less

Track Another Package

Enter tracking or barcode numbers

Need More Help?

Contact USPS Tracking support for further assistance.

FAQs

UNITED STATES POSTAL SERVICE

March 6, 2024

Dear Mercedes Fuentes:

The following is in response to your request for proof of delivery on your item with the tracking number: **9171 9690 0935 0241 6158 93**.

Item Details	
Status:	Delivered, Front Desk/Reception/Mail Room
Status Date / Time:	February 27, 2024, 10:56 am
Location:	LAS VEGAS, NV 89121
Postal Product:	First-Class Mail®
Extra Services:	Certified Mail™
	Return Receipt Electronic

Shipment Details	
Weight:	0.6oz

Recipient Signature

Note: There is no delivery signature on file for this item.

Thank you for selecting the United States Postal Service® for your mailing needs. If you require additional assistance, please contact your local Post Office™ or a Postal representative at 1-800-222-1811.

Sincerely,
United States Postal Service®
475 L'Enfant Plaza SW
Washington, D.C. 20260-0004

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against	Case No.: 24-22461-1 and 24-22461-2
MATTHEW OBIM OKEKE, M.D.,	Early Case Conference Date: April 24, 2024 @ 11:00 a.m.
Respondent.	

ORDER SCHEDULING EARLY CASE CONFERENCE

TO: Sarah A. Bradley, J.D., MBA
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste 280
Las Vegas, NV 89121

FILED
MAR 20 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

NOTICE IS HEREBY GIVEN that, in compliance with NRS 630.339(3), **an Early Case Conference will be conducted for the above-referenced matter on April 24, 2024 beginning at the hour of 11:00 a.m.** The Early Case Conference will be held via conference call. The conference call number is 1-605-475-2200 and the access code is 8792457.[1]

[1] NRS 630.339(3) provides as follows:

> Within 20 days after the filing of the answer, the parties shall hold an early case conference at which the parties and the hearing officer appointed by the Board or a member of the Board must preside. At the early case conference, the parties shall in good faith:
>
> (a) Set the earliest possible hearing date agreeable to the parties and the hearing officer, panel of the Board or the Board, including the estimated duration of the hearing:
>
> (b) Set dates:
>
> (1) By which all documents must be exchanged;
> (2) By which all prehearing motions and responses thereto must be filed;

The scheduled Early Case Conference shall be attended by the parties in person or by any party's legal counsel of record and will be conducted by the undersigned Hearing Officer to discuss and designate the dates for the Pre-Hearing Conference and Hearing and the other procedural matters established in NRS 630.339. The parties must also provide an estimate, to the nearest hour, of the time required for presentation of their respective cases.

At the Pre-Hearing Conference, in accordance with NAC 630.465,[2] each party shall provide the other party with a copy of the list of witnesses they intend to call to testify, including therewith, the qualifications of each witness so identified and a summary of the testimony of each witness. If a witness is not on the list of witnesses, that witness may subsequently not be allowed to testify at the Hearing unless good cause is shown for omitting the witness from said list.[3] Likewise, all evidence, except rebuttal evidence, that is not provided to each party at the Pre-

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(3) On which to hold the prehearing conference; and
(4) For any other foreseeable actions that may facilitate the timely and fair conduct of the matter.

(c) Discuss or attempt to resolve all or any portion of the evidentiary or legal issues in the matter;
(d) Discuss the potential for settlement of the matter on terms agreeable to the parties; and
(e) Discuss and deliberate any other issues that may facilitate the timely and fair conduct of the matter.

[2] NAC 630.465 provides as follows:

1. At least 30 days before a hearing but not earlier than 30 days after the date of service upon the physician or physician assistant of a formal complaint that has been filed with the Board pursuant to NRS 630.311, unless a different time is agreed to by the parties, the presiding member of the Board or panel of members of the Board or the hearing officer shall conduct a prehearing conference with the parties and their attorneys. All documents presented at the prehearing conference are not evidence, are not part of the record and may not be filed with the Board.

2. Each party shall provide to every other party a copy of the list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness. A witness whose name does not appear on the list of proposed witnesses may not testify at the hearing unless good cause is shown.

3. All evidence, except rebuttal evidence, which is not provided to each party at the prehearing conference may not be introduced or admitted at the hearing unless good cause is shown.

4. Each party shall submit to the presiding member of the Board or panel or to the hearing officer conducting the conference each issue which has been resolved by negotiation or stipulation and an estimate, to the nearest hour, of the time required for presentation of its oral argument.

[3] In identifying a patient as a witness the parties are cautioned to omit from any pleadings filed with undersigned Hearing Officer any addresses, telephone numbers, social security numbers, or other personal information regarding such individual and to confine their submissions in this regard to the name of the witness, the relevancy of any testimony sought to be elicited from that witness, and a summary of the anticipated testimony.

Hearing Conference may also not be introduced or admitted at the Hearing unless good cause is shown.

Counsel for the Nevada State Board of Medical Examiners and the Respondent shall keep undersigned Hearing Officer advised of each issue which has been resolved by negotiation or stipulation, if any.

ACCORDINGLY, NOTICE IS HEREBY GIVEN that the possible sanctions authorized by NRS 630.352, NAC 630.555, and NRS 622.400 upon a finding of guilt to one or more of the Counts raised in said Board Complaint include the following:

A. Placement on probation for a specified period on any of the conditions specified in an order issued by the Board;

B. Administration of a public reprimand;

C. Placement of a limitation on Respondent's practice, or exclusion of one or more specified branches of medicine from Respondent's practice;

D. Suspension of Respondent's license for a specified period or until further order of the Board;

E. Revocation of Respondent's license to practice medicine;

F. A requirement that Respondent participate in a program to correct alcohol or drug dependence or any other impairment;

G. A requirement that there be specified supervision of Respondent's practice;

H. A requirement that Respondent perform public service without compensation;

I. A requirement that Respondent take a physical or mental examination, or an examination testing Respondent's competence;

J. A requirement that Respondent fulfill certain training or educational requirements, or both, as specified by the Board;

K. A fine not to exceed $5,000.00;

///

///

L. A requirement that the Respondent pay all costs incurred by the Board relating to this disciplinary proceeding, as more fully set forth in NRS 622.400.

DATED this 20th day of March 2024.

By: _____

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing ORDER SCHEDULING EARLY CASE CONFERENCE addressed as follows:

Sarah A. Bradley, J.D., MBA
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

9171 9690 0935 0241 6247 41

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste 280
Las Vegas, NV 89121

DATED this 25nd day of March 2024.

Valerie Jenkins
Signature

Valerie Jenkins
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against MATTHEW OBIM OKEKE, M.D., Respondent.	Case No.: 24-22461-1 24-22461-2 and 24-22461-3 Early Case Conference Date: April 24, 2024 @ 11:00 a.m.

AMENDED ORDER SCHEDULING EARLY CASE CONFERENCE
(Adding Matter 24-22461-3 to the Scheduled ECC Conference)

TO: Sarah A. Bradley, J.D., MBA
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste 280
Las Vegas, NV 89121

FILED
MAR 26 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

NOTICE IS HEREBY GIVEN that, in compliance with NRS 630.339(3), **an Early Case Conference will be conducted for the above-referenced matters on April 24, 2024 beginning at the hour of 11:00 a.m.** The Early Case Conference will be held via conference call. The conference call number is 1-605-475-2200 and the access code is 8792457.[1]

[1] NRS 630.339(3) provides as follows:

> Within 20 days after the filing of the answer, the parties shall hold an early case conference at which the parties and the hearing officer appointed by the Board or a member of the Board must preside. At the early case conference, the parties shall in good faith:
>
> (a) Set the earliest possible hearing date agreeable to the parties and the hearing officer, panel of the Board or the Board, including the estimated duration of the hearing:
>
> (b) Set dates:
>
> (1) By which all documents must be exchanged;

The scheduled Early Case Conference shall be attended by the parties in person or by any party's legal counsel of record and will be conducted by the undersigned Hearing Officer to discuss and designate the dates for the Pre-Hearing Conference and Hearing and the other procedural matters established in NRS 630.339. The parties must also provide an estimate, to the nearest hour, of the time required for presentation of their respective cases.

At the Pre-Hearing Conference, in accordance with NAC 630.465,[2] each party shall provide the other party with a copy of the list of witnesses they intend to call to testify, including therewith, the qualifications of each witness so identified and a summary of the testimony of each witness. If a witness is not on the list of witnesses, that witness may subsequently not be allowed to testify at the Hearing unless good cause is shown for omitting the witness from said list.[3]

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(2) By which all prehearing motions and responses thereto must be filed;
(3) On which to hold the prehearing conference; and
(4) For any other foreseeable actions that may facilitate the timely and fair conduct of the matter.

(c) Discuss or attempt to resolve all or any portion of the evidentiary or legal issues in the matter;
(d) Discuss the potential for settlement of the matter on terms agreeable to the parties; and
(e) Discuss and deliberate any other issues that may facilitate the timely and fair conduct of the matter.

[2] NAC 630.465 provides as follows:

1. At least 30 days before a hearing but not earlier than 30 days after the date of service upon the physician or physician assistant of a formal complaint that has been filed with the Board pursuant to NRS 630.311, unless a different time is agreed to by the parties, the presiding member of the Board or panel of members of the Board or the hearing officer shall conduct a prehearing conference with the parties and their attorneys. All documents presented at the prehearing conference are not evidence, are not part of the record and may not be filed with the Board.

2. Each party shall provide to every other party a copy of the list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness. A witness whose name does not appear on the list of proposed witnesses may not testify at the hearing unless good cause is shown.

3. All evidence, except rebuttal evidence, which is not provided to each party at the prehearing conference may not be introduced or admitted at the hearing unless good cause is shown.

4. Each party shall submit to the presiding member of the Board or panel or to the hearing officer conducting the conference each issue which has been resolved by negotiation or stipulation and an estimate, to the nearest hour, of the time required for presentation of its oral argument.

[3] In identifying a patient as a witness the parties are cautioned to omit from any pleadings filed with undersigned Hearing Officer any addresses, telephone numbers, social security numbers, or other personal information regarding such individual and to confine their submissions in this regard to the name of the witness, the relevancy of any testimony sought to be elicited from that witness, and a summary of the anticipated testimony.

Likewise, all evidence, except rebuttal evidence, that is not provided to each party at the Pre-Hearing Conference may also not be introduced or admitted at the Hearing unless good cause is shown.

Counsel for the Nevada State Board of Medical Examiners and the Respondent shall keep undersigned Hearing Officer advised of each issue which has been resolved by negotiation or stipulation, if any.

ACCORDINGLY, NOTICE IS HEREBY GIVEN that the possible sanctions authorized by NRS 630.352, NAC 630.555, and NRS 622.400 upon a finding of guilt to one or more of the Counts raised in said Board Complaint include the following:

A. Placement on probation for a specified period on any of the conditions specified in an order issued by the Board;

B. Administration of a public reprimand;

C. Placement of a limitation on Respondent's practice, or exclusion of one or more specified branches of medicine from Respondent's practice;

D. Suspension of Respondent's license for a specified period or until further order of the Board;

E. Revocation of Respondent's license to practice medicine;

F. A requirement that Respondent participate in a program to correct alcohol or drug dependence or any other impairment;

G. A requirement that there be specified supervision of Respondent's practice;

H. A requirement that Respondent perform public service without compensation;

I. A requirement that Respondent take a physical or mental examination, or an examination testing Respondent's competence;

J. A requirement that Respondent fulfill certain training or educational requirements, or both, as specified by the Board;

K. A fine not to exceed $5,000.00;

///

///

L. A requirement that the Respondent pay all costs incurred by the Board relating to this disciplinary proceeding, as more fully set forth in NRS 622.400.

DATED this 26th day of March 2024.

By: _____

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing AMENDED ORDER SCHEDULING EARLY CASE CONFERENCE addressed as follows:

Sarah A. Bradley, J.D., MBA
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

9171 9690 0935 0241 6248 02

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste 280
Las Vegas, NV 89121

DATED this 26th day of March 2024.

Valerie Jenkins
Signature

Valerie Jenkins
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against	Case No.s: 24-22461-1 24-22461-2 and 24-22461-3
MATTHEW OBIM OKEKE, M.D.,	
Respondent.	

FILED
APR 26 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

ORDER STAYING PROCEEDINGS

TO: Sarah A. Bradley, J.D., MBA
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste 280
Las Vegas, NV 89121

NOTICE IS HEREBY GIVEN that the above-captioned matters are hereby stayed pending confirmation of a potential settlement. As such, no scheduled briefing and hearing dates have been set. The parties shall update the below hearing officer of whether a settlement has been properly confirmed by no later than thirty (30) days from the date of the next Nevada State Board of Medical Examiners meeting. If the settlement is not properly confirmed, the parties shall confer and propose available dates for a status conference.

DATED this 24th day of April 2024.

By: _____
Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing ORDER STAYING PROCEEDINGS addressed as follows:

Sarah A. Bradley, J.D., MBA
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

9171 9690 0935 0241 6273 60

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste 280
Las Vegas, NV 89121

DATED this 26th day of April 2024.

Valerie Jenkins
Signature

Valerie Jenkins
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against	Case No.s: 24-22461-1 24-22461-2 and 24-22461-3
MATTHEW OBIM OKEKE, M.D.,	
Respondent.	

FILED

MAY 22 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

TO: Sarah A. Bradley, J.D., MBA
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste 280
Las Vegas, NV 89121

ORDER SCHEDULING STATUS CONFERENCE

NOTICE IS HEREBY GIVEN a status conference will be conducted for this matter on **Thursday, May 23, 2024, at 2:00 p.m.**, Pacific Standard Time, and will be held via a conference call. Unless directed otherwise prior to the scheduled date and time, the conference call number will be 1-605-475-2200 and the access code will be 8792457. The parties shall participate in the conference call by and through counsel and shall be prepared to discuss scheduling of an evidentiary hearing and related deadlines as well as any other matter(s) necessary to facilitate adjudication.

DATED this 20th day of May 2024.

By: _____
Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing ORDER SCHEDULING STATUS CONFERENCE addressed as follows:

Sarah A. Bradley, J.D., MBA
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste 280
Las Vegas, NV 89121

DATED this 22nd day of May 2024.

Valerie Jenkins
Signature

Valerie Jenkins
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and ComplaintS Against	Case No.s: 24-22461-1 24-22461-2 and 24-22461-3
MATTHEW OBIM OKEKE, M.D.,	
Respondent.	

FILED

MAY 24 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

TO: Sarah A. Bradley, J.D., MBA
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste 280
Las Vegas, NV 89121

SCHEDULING ORDER

In compliance with NAC 630.465, a pre-hearing conference will be conducted for all three identified matters on **June 27, 2024**, beginning at the hour of 10:00 a.m., Pacific Standard Time, and will be held via a conference call. Unless directed otherwise prior to the scheduled date and time of the pre-hearing conference, the conference call number will be 1-605-475-2200 and the access code will be 8792457. The parties shall participate in the conference call and the conference will be conducted before the undersigned hearing officer.

By the pre-hearing conference, in separate disclosures for each of the three matters, each party shall provide the other party with a copy of the list of witnesses he or she intends to call to testify, including the witness' qualifications as well as a brief summary of the witness' anticipated testimony. If a witness is not included in the list of witnesses, that witness may not be allowed to testify at the hearing unless good cause is shown. Likewise, all documentation sought to be relied

upon at the formal hearing shall be exchanged. If at the formal hearing any party seeks to rely upon documentation not previously produced as ordered, such documentation will not be permitted unless good cause is shown.

Any and all pre-hearing motions as may be brought in relation to any of the three matters shall be served and submitted to the undersigned hearing officer on or before **July 17, 2024**, and any oppositions or responses thereto shall be served and submitted to the undersigned hearing officer on or before **July 26, 2024**.

The formal hearing for matter 24-22461-1 is hereby scheduled for **September 9-11, 2024**; the formal hearing for matter 24-22461-2 is hereby schedule for **September 16-17, 2024;** and the formal hearing for matter 24-22461-3 is hereby schedule for **October 21-22, 2024**. The formal hearings will commence at 8:30 a.m., Pacific Standard Time, each day. Unless otherwise determined, counsel for the IC and the undersigned hearing officer shall attend from the Reno office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521, and Respondent and Respondent's counsel shall attend from the Las Vegas office of the Nevada State Board of Medical Examiners, 325 E Warm Springs Road, Suite 225, Las Vegas, Nevada 89119. Witnesses for the parties may appear in person from either location. Remote appearance requests for witnesses, if any, must be made in writing by **July 26, 2024** so related logistics can be addressed.

Following the hearings, the undersigned hearing officer will submit to the Board written findings and recommendations pursuant to NRS 622A.300 that, pursuant to NAC 630.470, will include a synopsis of the testimony taken at the hearings as well as a recommendation on the veracity of witnesses if there is conflicting evidence or if credibility of witnesses is a determining factor. Thereafter the Board will render its decisions. NAC 630.470.

Should the parties deem a status conference necessary at any juncture of the proceeding, they shall coordinate at least three proposed dates and times and may jointly email the undersigned hearing officer with the proposed dates and times and request a status conference and state the basis for the request.

Both parties shall keep the undersigned hearing officer apprised of each issue that has been resolved by negotiation or stipulation or of any other change in the status of this case.

DATED this 23rd day of May 2024.

By: _____

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing SCHEDULING ORDER addressed as follows:

Sarah A. Bradley, J.D., MBA
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste 280
Las Vegas, NV 89121

9171 9690 0935 0241 6279 19

DATED this 24th day of May 2024.

Valerie Jenkins
Signature

Valerie Jenkins
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against MATTHEW OBIM OKEKE, M.D., Respondent.	**Case No. 24-22461-2**

FILED
JUN 26 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) submits the following Prehearing Conference Statement in accordance with NAC 630.465 and the Hearing Officer's Scheduling Order filed on May 24, 2024.

I. LIST OF WITNESSES

The IC of the Board lists the following witnesses whom it may call at the hearing on the charges in the Complaint against Respondent filed herein:

a. Ernesto Diaz, Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Mr. Diaz is expected to verify documentary evidence obtained during the investigation of this case and testify regarding the investigation of this matter.

b. Johnna LaRue, Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Ms. LaRue is expected to verify documentary evidence obtained during the investigation of this case and testify regarding the investigation of this matter.

///

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

II. LIST OF EXHIBITS

The IC of the Board lists the following exhibits that it may introduce at the hearing on the charges and formal Complaint against the Respondent. Additionally, the IC of the Board reserves the right to rely on all exhibits listed in Respondent's prehearing conference statement and any supplement and/or amendment thereof.

EXHIBIT NO.	DESCRIPTION	BATES RANGE (NSBME)
1.	NSBME Allegation Letter to Dr. Okeke, Patient A (Dated 11/04/2019)	0001-0004
2.	NSBME Allegation Letter to Dr. Okeke, Patients A–E (Dated 02/26/2020)	0005-0009
3.	Dr. Okeke's Response to Allegation Letter, Patient A (Dated 11/07/2019)	0010
4.	Dr. Okeke's Response to Allegation Letter, Patients B-E (Received 03/11/2020)	0011-0012
5.	NSBME Subpoena Duces Tecum, dated 06/21/2024, and Flight Records Produced from Delta Airlines	0013-0020
6.	Nevada Prescription Monitoring Program, Prescriber Activity Report for Dr. Okeke (Date Ranges 01/01/2019 – 12/31/2019)	0021-0160
7.	Medical Records for Patient A, Grand Desert Medical	0161-0338
8.	Affidavit of Records, Walgreens Pharmacy, and Prescription Records, Patient A (Date Ranges 08/01/2017 – 10/24/2019)	0339-0357
9.	Las Vegas Metropolitan Police Department Affidavit (Dated 12/13/2019) and Records in Response to NSBME Subpoena Duces Tecum (Dated 12/3/2019), Patient A	0358-0374
10.	Nevada Prescription Monitoring Program, Patient Query History, Patient A	0375-0379
11.	Nevada Prescription Monitoring Program, Utilization Report, Patient A	0380-0383
12.	Prescription Records for Patient B	0384-0387
13.	Billing Records for Patient B	0388-0408
14.	Medical Records for Patient B, Grand Desert Psychiatric Services	0409-0512
15.	Nevada Prescription Monitoring Program, Patient Query History, Patient B	0513

EXHIBIT NO.	DESCRIPTION	BATES RANGE (NSBME)
16.	Nevada Prescription Monitoring Program, Utilization Report, Patient B	0514-0516
17.	Prescription Records, Patient C	0517-0518
18.	Nevada Prescription Monitoring Program, Patient Query History, Patient C	0519-0520
19.	Nevada Prescription Monitoring Program, Utilization Report, Patient C	0521-0523
20.	Prescription Records, Patient D	0524-0525
21.	Medical Records for Patient D, Sana Behavioral Health	0526-0591
22.	Billing Records for Patient D	0592-0601
23.	Nevada Prescription Monitoring Program, Patient Query History, Patient D	0602-0603
24.	Nevada Prescription Monitoring Program, Utilization Report, Patient D	0604-0606
25.	Prescription Records, Patient E	0607-0608
26.	Medical Records for Patient E, Sana Behavioral Health	0609-0742
27.	Billing Records for Patient E	0743-0747
28.	Nevada Prescription Monitoring Program, Patient Query History, Patient E	0748-0749
29.	Nevada Prescription Monitoring Program, Utilization Report, Patient E	0750-0751
30.	FSMB Guidelines for the Chronic Use of Opioid Analgesics, April 2017	0752-0773
31.	21 CFR Part 1306, Role of Authorized Agents in Communicating Controlled Substance Prescriptions to Pharmacies, Vol. 75, No. 193, October 6, 2010, Rules and Regulations	0774-0778
32.	Jayleen Chen, M.D.'s Curriculum Vitae	0779-0780

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

The IC reserves the right to use any exhibits relied upon or identified by Respondent and reserves the right to amend and supplement this list of exhibits as required prior to the Prehearing Conference.

DATED this 26th day of June, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
Deputy Executive Director
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: bradleys@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaints Against	Case No.s: 24-22461-1 24-22461-2 24-22461-3 and 24-22461-4
MATTHEW OBIM OKEKE, M.D.,	
Respondent.	

FILED

JUN 28 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

TO: Sarah A. Bradley, J.D., MBA
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste 280
Las Vegas, NV 89121

AMENDED SCHEDULING ORDER
(Adding Matter 24-22461-4 and Updating Hearing Dates)

Matter 24-22461-4 Prehearing Conference

In compliance with NAC 630.465, a pre-hearing conference for matter 24-22461-4 will be conducted **August 21, 2024**, beginning at the hour of 11:30 a.m., Pacific Standard Time, and will be held via a conference call. Unless directed otherwise prior to the scheduled date and time of the pre-hearing conference, the conference call number will be 1-605-475-2200 and the access code will be 8792457. The parties shall participate in the conference call and the conference will be conducted before the undersigned hearing officer.

By the pre-hearing conference, each party shall provide the other party with a copy of the list of witnesses he or she intends to call to testify, including the witness' qualifications as well as a brief summary of the witness' anticipated testimony. If a witness is not included in the list of

witnesses, that witness may not be allowed to testify at the hearing unless good cause is shown. Likewise, all documentation sought to be relied upon at the formal hearing shall be exchanged. If at the formal hearing any party seeks to rely upon documentation not previously produced as ordered, such documentation will not be permitted unless good cause is shown.

Respondent's Disclosures for 24-22461-1; 24-22461-2; 24-22461-3

Respondent shall have up to and including June 28, 2024, by which to make the prehearing disclosures for matters 24-22461-1; 24-22461-2; 24-22461-3 subject to the same admonitions as set forth in the preceding paragraph.

Prehearing Motions for Matter 24-22461-4

Any and all pre-hearing motions as may be brought in relation to matter 24-22461-4 shall be served and submitted to the undersigned hearing officer on or before **September 4, 2024**, and any oppositions or responses thereto shall be served and submitted to the undersigned hearing officer on or before **September 17, 2024**.

Formal Hearing for All Four Pending Matters

The formal hearing for all four pending matters is hereby schedule for **October 21-24, 2024**, with an additional hearing date set for **November 21, 2024**, if needed. Such matters shall be heard consecutively starting with the first matter, 24-22461-4, unless otherwise agreed by the parties. The hearing will commence at 8:30 a.m., Pacific Standard Time, each day. Unless otherwise determined, counsel for the IC and the undersigned hearing officer shall attend from the Reno office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521, and Respondent and Respondent's counsel shall attend from the Las Vegas office of the Nevada State Board of Medical Examiners, 325 E Warm Springs Road, Suite 225, Las Vegas, Nevada 89119. Witnesses for the parties may appear in person from either location. Remote appearance requests for witnesses, if any, must be made in writing by **September 17, 2024** so related logistics can be addressed.

Following the hearings, the undersigned hearing officer will submit to the Board written findings and recommendations pursuant to NRS 622A.300 that, pursuant to NAC 630.470, will include a synopsis of the testimony taken at the hearings as well as a recommendation on the

veracity of witnesses if there is conflicting evidence or if credibility of witnesses is a determining factor. Thereafter the Board will render its decisions. NAC 630.470.

Should the parties deem a status conference necessary at any juncture of the proceeding, they shall coordinate at least three proposed dates and times and may jointly email the undersigned hearing officer with the proposed dates and times and request a status conference and state the basis for the request.

Both parties shall keep the undersigned hearing officer apprised of each issue that has been resolved by negotiation or stipulation or of any other change in the status of this case.

DATED this 27th day of June 2024.

By: _____

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing AMENDED SCHEDULING ORDER addressed as follows:

Sarah A. Bradley, J.D., MBA
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste 280
Las Vegas, NV 89121

9171 9690 0935 0254 6110 66

DATED this 28th day of June 2024.

Valerie Jenkins
Signature

Valerie Jenkins
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **MATTHEW OBIM OKEKE, M.D.,** **Respondent.**	**Case Nos. 24-22461-1** **24-22461-2** **24-22461-3**

FILED
JUN 2 6 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

AFFIDAVIT OF SERVICE

I, Mercedes Fuentes, Legal Assistant, as an employee of the Nevada State Board of Medical Examiners, being first duly sworn, declare under penalty of perjury under the laws of the State of Nevada that the following assertions are true to the best of my knowledge and:

On June 26, 2024, I personally served the following to Ms. Patricia Halstead, Esq., at Halstead Law Offices, 615 S. Arlington Avenue, Reno, Nevada 89509:

1. One (1) encrypted flash drive containing the IC's Prehearing Conference Statements and disclosures for Case Nos. 24-22461-1, 24-22461-2, and 24-22461-3.

Further your Affiant sayeth naught.

MERCEDES FUENTES
Legal Assistant

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

SUBSCRIBED and SWORN to before me by Mercedes Fuentes on this 26th day of June, 2024.

Notary Public

MARGARET F BYRD
Notary Public
State of Nevada
Appt. No. 10-3277-2
My Appt. Expires Sep. 3, 2026

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **MATTHEW OBIM OKEKE, M.D.,** **Respondent.**	**Case Nos. 24-22461-1** **24-22461-2** **24-22461-3**

FILED
JUL - 3 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

AFFIDAVIT OF SERVICE

I, George Tuioti, Deputy Chief of Investigations as an employee of the Nevada State Board of Medical Examiners, being first duly sworn, declare under penalty of perjury under the laws of the State of Nevada that the following assertions are true to the best of my knowledge and:

On June 26, 2024, I personally served the following to Mr. Liborious Agwara, Esq., at the Law Offices of Libo Agwara, Ltd., 2785 E. Desert Inn Rd., Ste 270, Las Vegas, NV 89121.

1. One (1) encrypted flash drive containing the IC's Prehearing Conference Statements and disclosures for Case Nos. 24-22461-1, 24-22461-2, and 24-22461-3.

Further your Affiant sayeth naught.

George Tuioti
Deputy Chief of Investigations

STATE OF NEVADA)
) ss.
COUNTY OF CLARK)

SUBSCRIBED and SWORN to before me by George Tuioti on this 26th day of June, 2024.

Notary Public

MALIA R. KAEO
Notary Public, State of Nevada
Appointment No. 22-2315-01
My Appt. Expires Sep 14, 2026

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against MATTHEW OBIM OKEKE, M.D., Respondent.	**Case No. 24-22461-2**

FILED

OCT 29 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

POST-HEARING FILING OF EXHIBIT BY THE INVESTIGATIVE COMMITTEE

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) hereby submits Exhibit 33 for the record, that was previously admitted at the hearing held on October 23, 2024.

DATED this 29th day of October, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
Deputy Executive Director
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: bradleys@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 29th day of October, 2024, I served a file-stamped copy of the foregoing **POST-HEARING FILING OF EXHIBIT BY THE INVESTIGATIVE COMMITTEE**, via email, to the following parties:

MATTHEW OBIM OKEKE, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste. 270
Las Vegas, NV 89121
libolaw@yahoo.com
Respondent

PATRICIA HALSTEAD, ESQ.
615 S. Arlington Avenue
Reno, NV 89509
phalstead@halsteadlawoffices.com
Hearing Officer

DATED this 29th day of October, 2024.

Valerie Jenkins
VALERIE JENKINS
Legal Assistant
Nevada State Board of Medical Examiners