EXHIBIT A

U.S. Department of Justice
Drug Enforcement Administration

Office of the Administrator *Springfield, VA 22152*

OCT 2 5 2022

IN THE MATTER OF

Dr. David Bockoff, M.D.
8500 Wilshire Blvd, Suite 926
Beverly Hills, CA 90211-3107

DEA Certificate of Registration Number BB4591839

ORDER TO SHOW CAUSE AND IMMEDIATE SUSPENSION OF REGISTRATION

PURSUANT to Sections 303 and 304 of the Controlled Substances Act, Title 21, United States Code, Sections 823 and 824,

NOTICE is hereby given to inform Dr. David Bockoff, M.D. of the immediate suspension of Drug Enforcement Administration (DEA) Certificate of Registration (COR) No. BB4591839, pursuant to 21 U.S.C. § 824(d), because your continued registration constitutes "an imminent danger to the public health or safety." Notice is also given to afford you an opportunity to show cause before DEA at the DEA Hearing Facility located at 700 Army Navy Drive, 2nd Floor, Arlington, VA 22202, or at a location designated by the Administrative Law Judge, on November 29, 2022, or on such a subsequent date designated by the Administrative Law Judge (if you request such a hearing), as to why DEA should not revoke your registration pursuant to 21 U.S.C. § 824(a)(4), and deny any pending applications for renewal or modification of such registration, or for additional DEA registrations, because your continued registration is inconsistent with the public interest, as that term is defined in 21 U.S.C. § 823(f).

As detailed below, this order states DEA's basis for this Order to Show Cause and Immediate Suspension of Registration, including a ***non-exhaustive summary*** of facts and law at issue, as well as citations to laws and regulations that you have violated (*see* 21 C.F.R. §§ 1301.36(e) and 1301.37(c), which DEA construes *in pari materia*). In order to preserve your rights in these proceedings, you may appear in these revocation proceedings by filing a notice of appearance or request for hearing in the manner prescribed by regulations within 30 days from the receipt of this Order.

LEGAL REQUIREMENTS

A prescription for a controlled substance is legitimate only if "issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 C.F.R. § 1306.04(a); *see, e.g.*, *MacKay v. DEA*, 664 F.3d 808, 815 (10th Cir. 2011) (applying state law to determine if a prescription complied with 21 C.F.R. § 1306.04(a)); *Marcia L. Sills, M.D.*, 82 Fed. Reg. 36,423, 36,443-44 (2017) (discussing 21 C.F.R. § 1306.04(a)). "Careless or negligent handling of controlled substances creates the opportunity for diversion and [can] justify revocation or denial." *Paul J. Caragine, Jr.*, 63 Fed. Reg. 51,592, 51,601 (1998).

In addition to complying with the above-cited federal statutes and regulations, as a California practitioner, you also are required to comply with applicable California law and regulations including, but not limited to, the following:

- Cal. Health & Safety Code § 11153(a) which states that "[a] prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice."

- Cal. Bus. & Prof. Code § 725(a) which defines unprofessional conduct subject to sanction to include "[r]epeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs."

- Cal. Bus. & Prof. Code § 2234 which defines unprofessional conduct subject to sanction to include "[g]ross negligence;" "[r]epeated negligent acts;" "[i]ncompetence;" or "[t]he commissions of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon."

- Cal. Bus. & Prof. Code § 2242(a) which defines unprofessional conduct subject to sanction to include "[p]rescribing, dispensing, or furnishing [controlled substances] without an appropriate prior examination and a medical indication."

- Cal. Bus. & Prof. Code § 2266 which defines unprofessional conduct subject to sanction to include "failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients."

STANDARD OF CARE

1. California's applicable standard of care for the practice of medicine as outlined in Medical Board of California, *Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons*, (7th ed. 2013) (the Guide) indicates that during an examination the prescribing physician must:

    a. assess the patient's pain, physical and psychological functions, substance abuse history, and history of prior pain treatment;

b. assess any underlying or coexisting diseases or conditions, and order and perform diagnostic testing if necessary;

c. discuss the risks and benefits of using controlled substances and any other treatment modalities;

d. periodically review the course of pain treatment or gather any new information, if any, about the etiology of a patient's state of health;

e. give special attention to patients who, by their own words and actions, pose a risk for medication misuse and/or diversion; and

f. document the presence of a recognized medical indication for the use of a controlled substance.

Id. at 57-59.

2. In its *"Guidelines for the Prescription of Opioids for Chronic Pain,"* dated March 18, 2016, (CDC Guidelines), the Centers for Disease Control and Prevention (CDC) set forth principles that reflect the standard of care (including in the State of California) regarding the prescribing of opioids for chronic pain. Among other things, and as relevant here, the CDC Guidelines provide that "[c]linicians should continue opioid therapy only if there is a clinically meaningful improvement in pain and function that outweighs risk to patient safety." *Id.* at 19. Additionally, the Guidelines direct clinicians to address aberrant urine drug screen results with the patients. *Id.* at 31. They also instruct that "[c]linicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible," further cautioning that co-prescribing muscle relaxants and/or sedative hypnotics together with opioids may also pose a danger to patient safety. *Id.* at 31-32.

BACKGROUND

3. You are registered with DEA as a practitioner to handle controlled substances in Schedules II through V under DEA COR No. BB4591839. Your registered address is 8500 Wilshire Blvd., Suite 926, Beverly Hills, CA 90211. Your DEA COR expires by its own terms on July 31, 2025.

4. You are presently licensed in the State of California as a medical doctor with License No. C31290. Your state medical license expires by its own terms on July 31, 2024.

5. Your DEA COR should be revoked and any pending application for registration, modification, or renewal should be denied because you have committed such acts as would render your registration inconsistent with the public interest. *See* 21 U.S.C. §§ 823(f), 824(a)(4). DEA's investigation found that from at least January 2020, through June 2022, you issued numerous controlled substance prescriptions unlawfully. This conduct reflects negative experience in prescribing with respect to controlled substances

in violation of 21 U.S.C. § 823(f)(2). You also failed to comply with applicable federal and state laws relating to controlled substances in violation of 21 U.S.C. § 823(f)(4).

UNLAWFUL PRESCRIBING OF CONTROLLED SUBSTANCES

6. As described below, as recently as June 2022, you violated federal and California law by issuing prescriptions to five patients for Schedule II through V controlled substances outside the usual course of professional practice and not for a legitimate medical purpose.

PATIENT B.B.

7. Between January 2020, through June 2022, you issued prescriptions for controlled substances to Patient B.B. approximately on a monthly basis. These prescriptions included morphine sulfate 100mg (a Schedule II opioid), oxycodone 30mg (a Schedule II opioid), methadone 10mg (a Schedule II opioid).

8. You did so without conducting an appropriate evaluation, without appropriately establishing a medical justification, without proper medical records, without establishing appropriate medical necessity, and without conducting proper ongoing monitoring of the patient. Among other things:

   a. You failed to take an appropriate history, complete an appropriate examination, detail your assessment, or adequately document the medical plan.

   b. You failed to obtain informed consent prior to, and during, your prescribing of controlled substances.

   c. You failed to mitigate the risks of addiction and diversion by attempting to reduce controlled substance use or by utilizing safer alternatives.

   d. You failed to monitor patient compliance with your opioid prescribing. Specifically, you failed to order regular urine drug screening, and failed to properly address the results.

   e. You prescribed combinations of morphine sulfate 100mg, oxycodone 30mg, and methadone 10mg – opioids common for diversion and abuse – in high dosages. Further, you prescribed a significantly elevated daily dose of between 225-720 Morphine Milligram Equivalent (MME)[1], with no evidence of improvement in pain and function.

[1] Morphine milligram equivalency is a common numerical standard used to compare the potency of various opioids. During the time in which you were prescribing these opioids, the CDC has notified practitioners that patients are exposed to increased risk of overdose when receiving opioids in amounts greater than the equivalent of 50 MME per day, and has cautioned that providing a patient with over 90 MME per day should be avoided absent a "careful justification based on diagnosis and on [an] individualized assessment of benefits and risks." *See* CDC Guidelines at 22-23.

PATIENT E.C.

9. Between January 2020, through June 2022, you issued prescriptions for controlled substances to Patient E.C. approximately on a monthly basis. These prescriptions included fentanyl (a Schedule II opioid) in dosage amounts, 0.2, 0.4, 0.6, 0.8, and 1.2 mg., methadone 10mg, and meperidine 50mg (a Schedule II opioid).

10. You did so without conducting an appropriate evaluation, without appropriately establishing a medical justification, without proper medical records, without establishing appropriate medical necessity, and without conducting appropriate ongoing monitoring of the patient. Among other things:

    a. You failed to take an appropriate history, complete an appropriate examination, detail your assessment, or adequately document the medical plan.

    b. You failed to obtain informed consent prior to, and during, your prescribing of controlled substances.

    c. You failed to mitigate the risks of addiction and diversion by attempting to reduce controlled substance use or by utilizing safer alternatives.

    d. You failed to monitor patient compliance with your opioid prescribing. Specifically, you failed to order regular urine drug screening.

    e. You prescribed various dosages of fentanyl while also prescribing methadone 10mg and meperidine 50mg – all opioids common for diversion and abuse – in high dosages. Further, you prescribed a significantly elevated daily dose of between 598 and 918 MME, with no evidence of improvement in pain and function.

11. Your treatment regimen of fentanyl is not consistent with FDA approved usage.[2] Moreover, you failed to document why this drug was needed initially, reasons for its continued use, or that you obtained informed consent from the patient. These failures put the patient at higher risk for harm, including addiction, overdose, and death.

PATIENT P.J.

12. Between January 2020, through June 2022, you issued prescriptions for controlled substances to Patient P.J. approximately on a monthly basis. These prescriptions included oxycodone 30mg, methadone 10mg, and alprazolam 2mg (a Schedule IV benzodiazepine).

13. You did so without conducting an appropriate evaluation, without appropriately establishing a medical justification, without proper medical records, without establishing

[2] The FDA label for the ACTIQ® (fentanyl citrate) oral transmucosal lozenge, states that the primary purpose of the drug is for breakthrough cancer pain. Cephalon, Inc. (2021), https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/020747s053lbl.pdf

appropriate medical necessity, and without conducting proper ongoing monitoring of the patient. Among other things:

a. You failed to take and an appropriate history, complete an appropriate examination, detail your assessment, or adequately document the medical plan.

b. You failed to obtain informed consent prior to, and during, your prescribing of controlled substances.

c. You failed to mitigate the risks of addiction and diversion by attempting to reduce controlled substance use by utilizing safer alternatives.

d. You failed to monitor patient compliance with your opioid prescribing. Specifically, you failed to order regular urine drug screening.

e. You prescribed oxycodone while also prescribing methadone – both opioids common for diversion and abuse – in high dosages. Further, you prescribed a significantly elevated daily dose of between 780 and 960 MME, with no evidence of improvement in pain and function.

14. On multiple occasions, you prescribed opioids and a benzodiazepine, disregarding the CDC guidance to "avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible." Deborah Dowell, MD et al., *CDC Guidelines for Prescribing Opioids for Chronic Pain – United States, 2016*, 65 Morbidity and Mortality Weekly Report 1, 16, 31-32, March 18,2016.

15. DEA has held that these cocktails and are associated with diversion. *See, e.g., Jacobo Dreszer, M.D.*, 76 Fed. Reg. 19,386, 19,389 (2011). To the extent that prescribing the opioid and benzodiazepine cocktail was for a legitimate medical purpose while you were acting in the usual course of your professional practice, you failed to adequately document your reasoning.

PATIENT F.L.

16. Between January 2020, through June 2022, you issued prescriptions for controlled substances to Patient F.L. approximately on a monthly basis. These prescriptions included oxymorphone (a Schedule II opioid) in dosage amounts 10, 20, and/or 40mg, ketamine 5.75mg (a Schedule III sedative), and carisoprodol 350mg (a Schedule IV muscle relaxant).

17. You did so without conducting an appropriate evaluation, without appropriately establishing a medical justification, without proper medical records, without establishing appropriate medical necessity, and without conducting proper ongoing monitoring of the patient. Among other things:

a. You failed to take an appropriate history, complete an appropriate examination, detail your assessment, or adequately document the medical plan.

b. You failed to obtain informed consent prior to, and during, your prescribing of controlled substances.

c. You failed to mitigate the risks of addiction and diversion by attempting to reduce controlled substance use by utilizing safer alternatives.

d. You failed to monitor patient compliance with your opioid prescribing. Specifically, you failed to order regular urine drug screening.

e. You prescribed oxymorphone (an opioid) in various dosages while also prescribing carisoprodol (a muscle relaxant), and ketamine (a sedative) while the patient was receiving stimulant prescriptions from another doctor. Patient F.L. also suffered from asthma. These combinations, in combination with Patient F.L.'s asthma, placed the patient at risk for abuse and harm. Further, you prescribed a significantly elevated daily opioid dose of between 660 and 900 MME, with no evidence of improvement in pain and function.

PATIENT A.W.

18. Between January 2020, through June 2022, you issued prescriptions for controlled substances to Patient A.W. approximately on a monthly basis. These prescriptions included oxycodone 30mg and 80mg.

19. You did so without conducting an appropriate evaluation, without appropriately establishing a medical justification, without proper medical records, without establishing appropriate medical necessity, and without conducting proper ongoing monitoring of the patient. Among other things:

a. You failed to take and an appropriate history, complete an appropriate examination, detail your assessment, or adequately document the medical plan.

b. You failed to obtain informed consent prior to, and during, your prescribing of controlled substances.

c. You failed to mitigate the risks of addiction and diversion by attempting to reduce controlled substance use by utilizing safer alternatives.

d. You failed to monitor patient compliance with your opioid prescribing. Specifically, you failed to order regular urine drug screening, and failed to properly address the results.

e. You failed to adequately address Patient A.W.'s mental health diagnoses of schizoaffective and bipolar disorders, which could put Patient A.W. at higher risk for abuse and misuse of controlled substances.

f. You prescribed oxycodone in various dosages while the patient was receiving stimulant and opioid prescriptions from another doctor. These combinations placed the patient at risk for diversion, abuse and death. Further, you prescribed a

significantly elevated daily dose of 1,320 MME, with no evidence of improvement in pain and function.

INADEQUATE, ILLEGIBLE AND UNORGANIZED PATIENT RECORDS

20. Your documentation in patient records was poor and often illegible. The patient records were either blank, or provided minimal information. Upon execution of the warrant, patient records were found in several locations, including a garage storage facility and various locations within your office.

EXPERT REVIEW

21. DEA retained an independent medical expert to review (among other materials), information regarding all of the above-noted controlled substance prescriptions, as well as your patient files for Patients B.B., E.C., P.J., F.L., and A.W. Based on your numerous deviations from the standard of care in issuing the above-noted prescriptions, DEA's medical expert concluded that all of the above-noted controlled substance prescriptions violated minimal medical standards applicable to the practice of medicine in the State of California.

IMMINENT DANGER

22. As recently as June 2022, you have continued to unlawfully prescribe controlled substances. Given your significant history of unlawful prescribing set forth above, your ongoing prescribing of controlled substances in violation of the standard of care poses an "imminent danger" within the meaning of 21 U.S.C. § 824(d).

IN view of the foregoing, and pursuant to 21 U.S.C. §§ 823(f) and 824(a)(4), it is the Agency's preliminary finding that your continued registration is inconsistent with the public interest. It is the Agency's preliminary finding that you repeatedly dispensed controlled substances while repeatedly failing to provide effective controls and procedures to guard against diversion of controlled substances, which is inconsistent with the public interest. It is also the Agency's preliminary finding, based on the facts and circumstances described above and in light of the rampant and deadly problem of prescription controlled substance abuse, that your continued registration during the pendency of these proceedings would constitute "an imminent danger to the public health or safety" because of the substantial likelihood of an imminent threat that death, serious bodily harm, or abuse of controlled substances will occur in the absence of this suspension. Under the facts and circumstances described herein, it is the Agency's conclusion that your continued registration while these proceedings are pending constitutes "an imminent danger to the public health or safety." *See* 21 U.S.C. § 824(d). Accordingly, pursuant to the provisions of 21 U.S.C. § 824(d) and 21 C.F.R. § 1301.36(e), and the authority granted to the Agency under 28 C.F.R. § 0.100, DEA COR No. BB4591839 is hereby suspended effective immediately. Such suspension shall remain in effect until a final determination is reached in these proceedings.

PURSUANT to 21 U.S.C. § 824(f) and 21 C.F.R. § 1301.36(f), the Special Agents and Diversion Investigators of DEA who serve this Order to Show Cause and Immediate Suspension