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ISMP Institute for Safe Medication Practices
An ECRI Company

Community/Ambulatory Care

ISMP Medication Safety Alert!®

Educating the Healthcare Community About Safe Medication Practices

Counterfeit semaglutide leads to ED visit: Warn patients about buying counterfeit drugs online

Problem: A patient presented to the emergency department (ED) with uncontrolled nausea and vomiting after injecting what is presumed to be a 10 mg dose of semaglutide, rather than the intended 0.5 mg dose. They were treated with intravenous (IV) 0.9% sodium chloride, metoclopramide, and ondansetron and discharged 24 hours later with prescriptions for antiemetics to treat the persistent side effects.

The patient told the ED staff that their provider had prescribed **WEGOVY** (semaglutide) for obesity, but they could not afford the copay. Consequently, the patient purchased what they believed was semaglutide for $500 through an internet website (the website was not shared with ISMP). The patient was not provided with education on how to prepare or administer the dose. When the product arrived, the United States Postal Service label indicated it came from what appeared to be a residential address.

Figure 1. The "sterile water" diluent came in unlabeled glass ampules, without a filter needle or straw.

The contents of the shipping container included several irregularities that would not be expected if the product had been dispensed by a legitimate pharmacy. It did not include a patient-specific label with instructions for use, properly labeled drug containers, or all the necessary supplies to safely prepare and administer the drug. The shipped cardboard box contained the following items:

- Glass ampules reportedly containing "sterile water" with no labels (**Figure 1**)
- 50-unit (0.5 mL) insulin syringes but no filter needles or straws to withdraw the contents from the glass ampules
- 10 vials with container labels that indicated the vials contained 10 mg of semaglutide sterile lyophilized powder but did not include a national drug code (NDC) or other drug identification number (**Figure 2**, page 2); the labels did contain a lot number (ZPHC768) and expiration date (03/2027), which does not comply with current USP General Chapter <7> *Labeling* requirements expiration date formats (e.g., YYYY-MM).

The carton containing the 10 vials of lyophilized powder displayed other anomalies. The carton label stated that the product was "Produced by SecureSemaglutide Labs" and that it was "SWISS MADE" and had a "GMP" seal indicating it was manufactured in a good manufacturing practice facility (**Figure 3**, page 2). Although semaglutide is indicated for subcutaneous injection only, the carton stated, "To Be Injected Subcutaneous or Intramuscular." In addition, semaglutide should not be frozen but the carton stated, "Store frozen at -25°C to -15°C (-13°F to 5°F) for long-term storage."

A panel of the carton contained instructions to mix 1 mL of "sterile water" into the "vail" (i.e., vial) and that the initial dose was to be 0.5 mg injected subcutaneously once weekly, with titration

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Another pharmacy delivery error. A patient inadvertently took another patient's medication for more than a month after it was delivered to the wrong address. The two patients, who are next-door neighbors in an apartment complex, both receive pharmacy deliveries. The medications that were incorrectly received included **ELIQUIS** (apixaban) 5 mg twice daily, atorvastatin 80 mg once daily, levothyroxine 175 mcg once daily, and **JARDIANCE** (empagliflozin) 10 mg once daily. The error was not detected until the patient called to refill one of the medications, stating that it was prescribed by a doctor whose name matched that of the neighbor for whom the medication was actually prescribed. He had apparently read the patient's name on the label and assumed it was the doctor's name. Thankfully, the patient reported feeling fine, despite the potential for serious bleeding events with Eliquis and other adverse effects from the other medications.

To prevent such errors, if the pharmacy uses its own delivery personnel, educate the drivers to ask the patient (or the person accepting the package) to state the patient's full name and address (or date of birth) and have the driver verify at least two of these identifiers against the delivery information on the package label. If you use an external courier service, meet with them to discuss issues and errors, and implement risk-reduction strategies. Collaborate with them to ensure staff are properly educated and competent, including how to verify the patient's identity and address before handing over the prescription(s). Always educate patients to immediately open the prescription package, check the contents of each prescription container to confirm it is the correct patient and drug, and call the pharmacist with any concerns or questions.

A known look-alike name pair that continues to cause confusion. A physician ordered sulfa**SALA**zine 500 mg

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information (**Figure 4**). The instructions did not specify the volume that the patient should administer for the dose. However, if the vial contained 10 mg of drug and if the patient was to dilute it with 1 mL (10 mg/1 mL), then the initial dose would have been 0.5 mg/0.05 mL. From what the ED staff understood, the patient administered a full 10 mg vial (1 mL) using two 50-unit insulin syringes.

While some issues may be more noticeable to healthcare practitioners than patients, there were several other clues that something was not right:

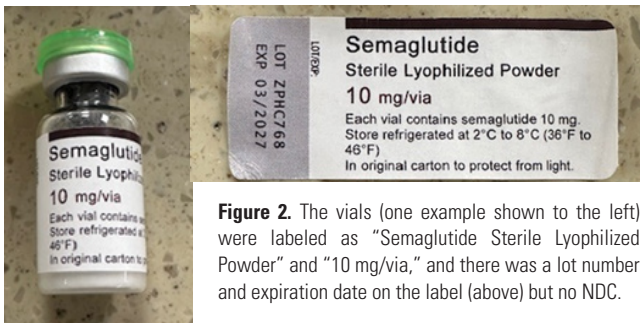

Figure 2. The vials (one example shown to the left) were labeled as "Semaglutide Sterile Lyophilized Powder" and "10 mg/via," and there was a lot number and expiration date on the label (above) but no NDC.

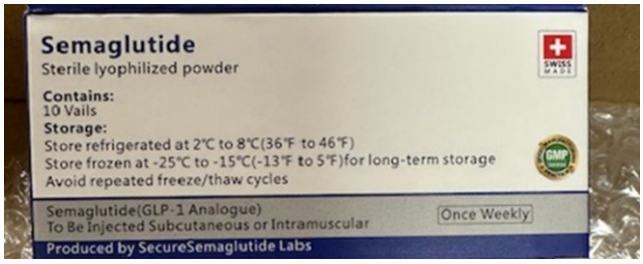

Figure 3. The carton label indicated the product is "Produced by SecureSemaglutide Labs," "SWISS MADE," with a "GMP" seal, and that it is "To Be Injected Subcutaneous or Intramuscular."

- The drug was purchased without a prescription online "from Switzerland"
- The patient was not provided with education, and there was no pharmacist available for counseling
- There was no contact information (i.e., phone number) for follow-up questions
- There was no patient-specific label or instructions about what volume to administer
- The word vial was misspelled on the labels (e.g., "via" on the vial label, "vail" on the carton label)
- The "sterile water" ampules did not have labels
- There was no NDC or drug identification number
- Although the carton stated the drug should be refrigerated, it was not shipped with cold packs
- The carton label contained an unapproved route of administration (i.e., intramuscular) for semaglutide
- There was no beyond-use date (BUD) information provided for the reconstituted product

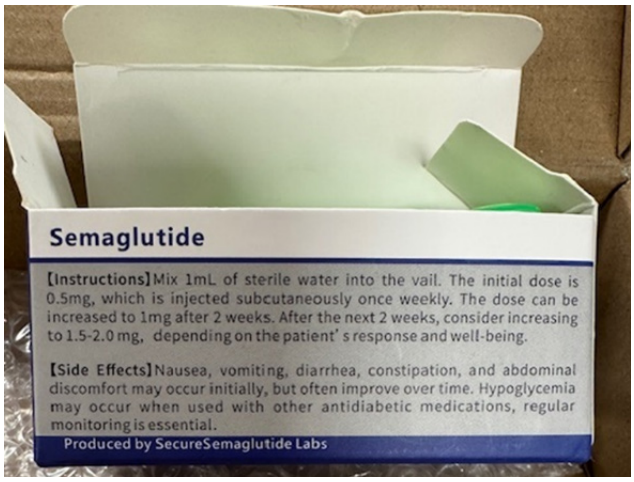

Figure 4. The instructions lack the information about the volume needed to administer a dose.

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tablets for a patient. Sulfa**SALA**zine is a disease modifying antirheumatic approved to treat rheumatoid arthritis, juvenile arthritis, and ulcerative colitis. However, the pharmacy technician entered into the pharmacy computer system sulf**ADIAZINE** 500 mg tablets, an antibiotic. The error was not caught during pharmacist verification, and the prescription was dispensed to the patient. The patient took the medication but thankfully did not experience any harm.

This is not the first time we have received reports of mix-ups between these drugs. We first wrote about this pair in the February 2010 issue of this newsletter. These drugs share many characteristics that increase the risk of error. Both drugs are available in 500 mg tablet strengths. Both drug names begin with "sulfa" and end with "azine." Also, because both drug names begin with "sulfa," they are likely to be stored near one another.

Due to how much these drug names look alike, we have published tall man lettering schemes for them (i.e., sulfa**SALA**zine and sulf**ADIAZINE**). We encourage the use of these tall man lettering schemes where the drug names appear in computer systems, in electronic prescriptions, and on any labels applied to pharmacy shelves. Prescribers should include the purpose of the drug on prescriptions to help inform the pharmacist of the patient's condition and ensure the correct medication is selected. Pharmacies may also consider separating the storage locations for these drugs. Make sure staff are aware that the medications have been separated and where to locate them.

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Share Your Stories with Us

Articles in this publication are based on actual reports from practitioners. We'd like to hear from you, too! Please share reports of medication errors and prevention recommendations, in confidence, with colleagues in the United States and worldwide. Errors may be reported online or by calling 1-800-FAIL-SAF(E). ISMP guarantees the confidentiality of information received.

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Safe Practice Recommendations: Pharmacies and medical offices play a crucial role in raising awareness of the threat of substandard and falsified (SF) (or counterfeit) drugs to patients. Share this case with your staff as well as outpatient and specialty pharmacy medication safety committees. Provide widespread education to practitioners that about 95% of so-called online pharmacies operate illegally.[1] Leaders and staff must stay informed about medication-related incidents shared by safety organizations and develop mitigation strategies for known problematic drugs, including glucagon-like peptide-1 (GLP-1) agonists. If patients present with unexpected outcomes (e.g., increased side effects), consider if SF medications could be the culprit. When reviewing a patient's medication history, include a scripted open-ended question asking where they obtain their medications.

Share with patients the warning signs, like those described above, that may indicate a pharmacy could be selling SF drugs. Refer them to resources such as the US Food and Drug Administration's (FDA) BeSafeRx campaign. Educate patients about the National Association of Boards of Pharmacy's (NABP) searchable list of accredited digital pharmacies that comply with quality assurance criteria. Encourage patients to check for a licensed pharmacist's availability at any online pharmacy they are considering, which can help determine the pharmacy's legitimacy. Inform patients that when a pharmacy does not require a provider's prescription to dispense a prescription medication, the facility is likely illegal and unsafe.

Ask patients to review medication packages and labels for errors. Ensure the drug comes with patient-specific dosing instructions and information about how to prepare and administer the dose. Patients should be suspicious if vials are not labeled, if they are not provided with an appropriate measuring device, or if the drug is not shipped according to the storage requirements on the label (e.g., states to refrigerate but does not come with cold packs). Reinforce with patients that if anything does not look right, they should check with a healthcare practitioner before taking or administering the medication.

Reference

1) Brady J, Baney L. Congress holds registries and registrars accountable for rogue online pharmacies. National Association of Boards of Pharmacy (NABP). January 21, 2022. Accessed May 30, 2025.

Special Announcements

Nominations open for CHEERS AWARDS

Each year, ISMP honors various healthcare disciplines that have demonstrated an exemplary commitment to medication safety through innovative projects with an ISMP **CHEERS AWARD**. Nominations for this year's **CHEERS AWARDS** are now open and will be accepted through **August 1, 2025**. For more details and to submit a nomination, click here.

Short survey on automated dispensing cabinets (ADCs)

Med Safety Board, an ISMP company, is surveying the safe use of ADCs regarding storage configurations, error risks, and medication access concerns. The survey is for all healthcare professionals involved with ADCs. Please complete the short survey by **June 30, 2025**.

To subscribe: www.ismp.org/ext/1369

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Pharmacists should review the prescription label with the patient, confirm the indication, and ensure it is the medication they expect.

Look-alike bottles of levoFLOXacin and deferasirox. A pharmacy reported that when they were receiving and putting away their medication delivery from their wholesaler, they identified that bottles of levo**FLOX**acin 750 mg tablets look similar to bottles of deferasirox 360 mg tablets, both manufactured by Camber Pharmaceuticals (**Figure 1**). For example, the company name is placed at the top of both labels (rather than the drug names). Also, vertical blue stripes on the left side of the label and blue color backgrounds for the dosage strength make the bottles look almost identical.

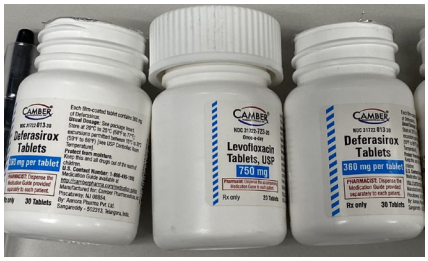

Figure 1. Bottles of levo**FLOX**acin (middle bottle) and deferasirox (left and right bottles), both manufactured by Camber Pharmaceuticals, look similar and can be confused for one another.

A mix-up of these two products could lead to patient harm. Deferasirox is a chelating agent used to treat chronic iron overload due to blood transfusions and in non-transfusion-dependent thalassemia syndromes. It carries *Boxed Warnings* for acute renal and hepatic failure as well as gastrointestinal hemorrhages. Levo**FLOX**acin, a fluoroquinolone antibiotic, also carries *Boxed Warnings*. The use of levo**FLOX**acin has been associated with disabling and potentially irreversible serious adverse reactions, including tendinitis and tendon rupture.

The pharmacy stated that they will be purchasing deferasirox from a different manufacturer to minimize the risk of look-alike similarities with these products. We agree with this strategy. They have also decided to block the ability to order deferasirox 360 mg from Camber for future orders. Also, barcode scanning each container when receiving and dispensing these products can help intercept errors before they reach patients.