NATIONAL APOTHECARY SOLUTIONS

OFFICE USE ONLY: Account Origination

Referred	□
Marketing	□
Relation with other account OPEN in system	□
Walk-in/Call-in	□

Company Name_____ Phone (_____)_____

Billing Address_____ Fax (_____)_____

City_____ **State** _____ **Zip Code**_____ Email_____

Account Payable Contact:_____ Phone: _____Email _____

Type of Company: □ Proprietorship □ Corporation □ Partnership □ Other:_____ Years in business_____

IF Corporation: Date Incorporated: _____State: _____ CEO:_____

Email_____

Customer DEA registration (please attach copy)_____ Purchase order required? Yes _____No_____

Type of Business: Home Healthcare_____ Hospital____ Pharmacy____ Clinic_____ Other_____

Name of Owners / Officers Phone E-mail .

_____

_____

Purchasing Contact:_____ **Phone:** _____**Email** _____

Credit References / References you made purchases from within the last 6 months

1)_____

2)_____

3)_____

Banking Information / Bank Name:_____

Officer_____Account #_____

The undersigned buyer (the "buyer") hereby authorizes Atlantic Biologicals Corp DBA National Apothecary Solutions to contact the above listed bank and credit references in order to verify the information provided above. By signing below, the buyer understands and agrees that all payments must be received by Atlantic Biologicals Corp DBA National Apothecary Solutions no later than 30 calendar days after buyer's receipt of product from Atlantic Biologicals Corp DBA National Apothecary Solutions and that time is of the essence with respect to all such payments. Atlantic Biologicals Corp DBA National Apothecary Solutions does not accept returns of products for any reason unless (i) the reason for buyer's request to return products arises directly from the gross negligence of Atlantic Biologicals Corp DBA National Apothecary Solutions or (ii) Atlantic Biologicals Corp DBA National Apothecary Solutions, in its sole and absolute discretion, agrees in writing to accept the return of any products from purchaser. In the event Atlantic Biologicals Corp DBA National Apothecary Solutions agrees in writing to accept the return of any products, buyer agrees such returns will be processed in accordance with Atlantic Biologicals Corp DBA National Apothecary Solution's return policies in effect at the time of the return. This Agreement and the rights and obligations hereunder will be construed, interpreted, and enforced in accordance with and governed by the laws of the State of Florida, without regard to conflict of laws principles. If Atlantic Biologicals Corp DBA National Apothecary Solutions becomes a party to any dispute, suit or proceeding with or relating to purchaser, Atlantic Biologicals Corp DBA National Apothecary solution's costs, expenses and reasonable attorneys' fees, whether or not suit is instituted, will be paid by buyer to Atlantic Biologicals Corp DBA National Apothecary Solutions immediately upon written demand. Any dispute, action or proceeding arising out of or relating to this Agreement must be brought in the courts of the State of Florida located in Miami Dade County or in the United States District Court for the Southern District of Florida and purchaser irrevocably submits to the exclusive jurisdiction of each such court in any such dispute, action or proceeding, waives any objection it may now or hereafter have to venue or to convenience of forum. Buyer agrees that buyer's rights, duties and obligation under this Agreement are not assignable by operation of law or otherwise. This Agreement represents the full and complete understanding of the parties with respect to the subject matter hereof and cannot be modified (whether by subsequent electronic mail communication, purchase order, invoice or otherwise) or terminated except by writing and signed by both parties.

Date **Buyer's Signature** **Name (please print)**

INDIVIDUAL GUARANTEE: I (we) the undersigned, in consideration of National Apothecary Solutions., opening an account with / or extending credit to the above named corporation pursuant to the application of my (our) request as an officer, director, stock holder of the company, herby personally (and jointly and severally if more than one) guarantee payment of debts and all legal and other costs of collection incurred in collection with the aforesaid credit. National Apothecary Solutions may obtain an individual credit report if deemed necessary.

Date **Signature** **Name (please print)**

Credit Card Authorization Form

CreditCard#:_____ExpirationDate:_____ CVV Code: _____

Name on card: _____
Bill to address (if different from above): _____ City: _____ State: _____
Zip Code: _____
Notes:_____

I authorize National Apothecary Solutions to charge my credit card for payment of their product and/or services. If National Apothecary Solutions is unable to process my payment, I will be responsible for an alternate payment arrangement and any resulting processing fees. By signing this authorization, I acknowledge that I have read and agree to all the above information and warrant all information given is true.
Signature: _____ Date: _____

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Do you intend to purchase controls?

NO

You have finished.

Upon completion of the form above, please attach the following

- Copy of State License- (DPS/State Controlled Substance Registration Certificate)
- Copy of DEA License- (DEA Controlled Substance Registration Certificate)

and submit via:

1. Email: Registration@NASRx.com
2. Fax: 954-507-6735
3. Mail: 20101 NE 16th Place Miami FL, 33179

YES

Please continue this form and ensure you have the following:

- Copy of Certificate(s)/License(s) from the state where the pharmacy is located and operates, for all employees who are:
  - Pharmacist in Charge
  - Additional Pharmacist(s) if applicable
  - Pharmacist Technician(s) I applicable
  - Pharmacist Technician(s) in Training (if applicable)
- One Year Drug Utilization Report (DUR):
  i. Pharmacy Name
  ii. Date of usage
  iii. Drug name and mg
  iv. NDC Number
  v. Total number of prescriptions; and
  vi. Quantity (e.g. count of capsules, tablets etc. in each Rx)
- Copies of government -issued identification for each owner, director, Pharmacist in Charge, Manager and/or Officer of Company (as applicable)
- SOP's (Standard Operating Procedures for controls within Pharmacy.

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REGULATORY QUESTIONNAIRE

Current name of pharmacy		
Type of incorporation		
List any DBAs or fictitious names		
Website URL		
Customer DEA Registration#		
Pharmacy NCPDP#		
Hours of Operation		
Name of Pharmacist in Charge		
Owner(s) Name		
Owner Phone Number		
Owner Email Address		
Number of Years Owned		
How many Prescriptions are Filled…	Daily:	Monthly:
What is the ratio of controlled substance vs. non-controlled substance orders?		
Please provide a list of names of all suppliers you have used within the last 24 months for Rx orders		
Name(s) of all pharmacy technicians (please attach a copy of certifications for each technician)		

	Questions	Y	N	N/A	Comments
1	Does the pharmacy offer a full assortment of sundries to its customers?				
2	Does the pharmacy have security guards on premise?				
3	Is the owner a licensed pharmacist?				
4	Has the owner ever had any license, registration, and/or permit suspended or revoked or had any disciplinary actions against them? If yes, provide details?				
5	Has owner, pharmacist in charge or technicians been convicted of any felony under a federal, state, or local law?				
6	Is the pharmacy a member of any professional associations? If yes, provide names?				
7	Does the pharmacy have any other certifications? If yes, please provide examples				
8	Does the pharmacy have any other licensing/registration (wholesale/repackages/etc.)? If yes, provide details				
9	Is the pharmacy a specialty pharmacy? If yes, please describe:				
10	Does the pharmacy provide services for any specialty customers such as Long-Term Care, Hospice, Assisted Living Facilities? If yes, provide detail:				
11	List your top prescribers, their percentage of control prescriptions, government Issued photo IDs and their DEA#s. Attach an additional sheet if needed. Attach one year of control usage reports (NAS will ask randomly for usage reports).				
12	Does the pharmacy fill prescriptions for pain management or other specialty practitioners (diet, oncology, etc.)?				
13	Does the pharmacy perform any type of validation of these prescriptions? If yes, please describe:				
14	Please provide a listing of Pain Management Specialists				
15	Has the pharmacy ever refused to fill prescriptions for a particular practitioner? If yes, why? And whom?				

Questions		Y	N	N/A	Comments
16	Is the Pharmacy comfortable with the prescribing practices of all the practitioners for which It fills prescriptions?				
17	Does the Pharmacy supply, order for, or sell to any practitioners for which it fills prescriptions?				
18	Is the Pharmacy a mail order pharmacy?				
19	Does the pharmacy fill prescriptions via the Internet?				
20	Is the Pharmacy registered with the DEA under the Ryan Haight Act?				
21	Does the Pharmacy fill prescriptions for out of state customers?				
22	If yes, how many out of state customers does the pharmacy fill? (Ratio or Approximate Number)				
23	Does the Pharmacy report to all states that have a prescription monitoring programs in which their customers reside and to whom they dispense?				
24	Is the Pharmacy licensed in all states for which it mails or fills prescriptions?				
25	Does the Pharmacy have any exclusive contracts, agreements, arrangements, etc., with any particular practitioner, business group, investors, etc.? If yes, please use a separate sheet to explain those arrangements and/or obtain copies of those agreements if applicable.				
26	Are prescriptions written by the physicians located in the state in which the patient resides?				
27	Does the Pharmacy employ measures to prevent diversion and/or patient addiction to controlled substances? If yes, please explain.				
28	Check the following manners of receiving business and provide what percentage of the total busine ss it compresses:				

29	Check the following manners of receiving business and provide what percentage of the total business compromises.	Walk-In	%	Fax	%
		Phone	%	Online	%
		Mail Order	%	Other	%

Questions		Y/N		Percentage
30	Check the following types of products and provide the approximate percentage of products you expect to purchase from Atlantic Biologicals/National Apothecary Solutions		OTC	%
			Non-Controlled Rx	%
			Controlled Substance	%
			Listed Chemicals	%
31	Check the following types of products and provide the approximate percentage of products you expect to purchase from other suppliers?		OTC	%
			Non-Controlled Rx	%
			Controlled Substance	%
			Listed Chemicals	%
32	Check the following types of payments accepted at the Pharmacy and provide the approximate percentage		Insurance	%
			Medicare/Medicaid	%
			Self-Pay	%
			Other	%
33	How does the Pharmacy sell/transfer controlled substances to other pharmacies or practitioners?		Prescription	%
			Sales Invoice	%
			DEA Form-222	%

NATIONAL APOTHECARY SOLUTIONS CONTROLLED SUBSTANCE PURCHASE REQUIREMENTS AND POLICIES CUSTOMER ACKNOWLEDGEMENT

National Apothecary Solutions (NAS) requires that every new, potential customer sign acknowledging the below information.

Information Requirements and Updates

- Periodic, random requests for usage reports
- Other prescribing information (number of scripts, etc.)
- Periodic, random requests for updated pharmacy information:
    - Principals
    - Pharmacy personnel (pharmacists, pharmacy technicians, etc.)
    - Prescribing physicians
    - Updated list of other control vendor suppliers
    - Pharmacy's busines model/description
    - Copies of current pharmacy license(s) and certifications
    - Standard Operating Procedures for filling and validating prescriptions, diversion
- Periodic, random audits of the following:
    - Pharmacy
    - Pharmacy principals
    - Pharmacy personnel (pharmacists, pharmacy technicians, etc.)
    - Prescribing physicians
- Justification for increases of CII's requests will be required
- Purchases must meet the "80/20" rule (80% of the order must be non-controls with 20% controls)
- Orders for CII's can be ordered via 222 forms, only 222 orders that are not fulfilled will be closed. There will be no open orders or backorders on a form
- Multiple 222 forms may be submitted within a calendar month
- Abide by the attached Returned Goods Policy

Laws and Regulations

"Buyer will……."

- …abide by all applicable laws, rules, regulations, ordinances and guidance of the federal Drug Enforcement Administration ("DEA"), the states into which it dispenses or sells controlled substances and/or listed chemicals, and the states in which it is licensed, including, without limitation, all of the foregoing concerning the purchase, sale dispensation and distribution of controlled substances
- …not dispense or sell controlled substances and/or listed chemicals if it suspects that a prescription or drug order is not issued for a legitimate medical purpose or the actions conducted on the part of the prescriber or Buyer and its employees are not performed in the normal course of professional practice.
- Buyer understands that NAS is required by DEA regulations to report to the DEA suspicious orders of controlled substances and listed chemicals, and Buyer agrees to act in good faith in assisting NAS to fulfill its obligations. Buyer agrees that it will

be alert for red flags of suspicious orders and listed chemicals, including but not limited to:

- Numerous controlled substance prescriptions written for the same drugs, in the same quantities for the same time period by the same or different prescribers of group of prescribers for the same patient,
- Numerous controlled substance prescriptions written for the same person or several persons by the same prescriber or group of prescribers; and
- Numerous prescriptions written for the same patient by prescribers located in different states than the patient.

Buyer agrees that if any of the above-noted or other red flags exist, it is prudent to contact the prescriber to validate the legitimacy of the prescription and/or to discontinue filling prescriptions

from the prescriber, group of prescribers or customer in question. In addition, the pharmacist should contact the State Board of Pharmacy or local DEA Diversion Field Office.

Buyer acknowledges that NAS may provide a copy of this document to the DEA or any other state or federal regulatory agency or licensing board."

National Apothecary Solutions Customer Name _____

By: _____ By: _____

Name: _____ Name: _____

Title: _____ Title: _____

Date: _____ Date: _____

If a physician administers medications in a licensed, approved medical facility (in-office), and is not ordering or administering CII's, they are not required to meet the 80/20 Rule (80% of the order must be non-controls with 20% controls).

Please proved an estimated monthly usage for each medication physician plans to purchase from NAS that are to be administered in-office.

Medication	Monthly Usage
Testosterone	
Phentermine	
Suboxone	
Other	
Other	

I, as the Owner or authorized representative or officer of the Company, do hereby attest that is aware of and complies with all laws and regulations enforced by the DEA and applicable State Authorities. All policies and procedures are maintained to ensure the distribution of Controlled Substances and precursor chemicals are for legitimate medical purposes and Controlled Substances are not diverted or made available to illicit channels.

Customer agrees to and understands that Atlantic Biologicals Corp. is required to report any instances of suspicious orders of controlled substances to the applicable DEA Diversion field authorities. Atlantic Biologicals Corp. reserves the right, at our sole discretion, in all cases to limit or eliminate sales of controlled substances to customers which it determines pose an issue of proper usage and/or adequate legal compliance.

Customer agrees to acknowledge his legal responsibility under 21CFR 1306.04 to ensure the proper prescribing and dispensing of controlled substances and to exercise due diligence to ensure compliance by its prescribers and patients with applicable laws and regulatory guidelines. Customer agrees to exercise professional knowledge, expertise and stay informed of all such legal and regulatory guidelines.

Customer agrees and understands that Atlantic Biologicals Corp. may provide a copy of this questionnaire to the DEA, other federal regulatory agencies, and any state regulatory agency where appropriate.

Customer acknowledges that this questionnaire is for the purchase of C-III's through C-IV's _____initials

I declare under the penalty of perjury the aforementioned is true and correct.

Signature_____

Full Name_____

Title_____

Date_____