AnazaoHealth®

Instructions on filling out the form and our contact information:

1. Complete, sign, and return the New Customer Set-Up Form along with Billing Information prior to the first order being shipped.
2. The completed New Customer Set-Up Form can be faxed, or emailed to:

Fax: 800.985.4363 (Attn: Sales) E-mail: CustomerService@anazaohealth.com

As a new customer, you will automatically be enrolled in our online ordering system ***myAnazao.com*** which allows the prescriber or staff to place/sign prescriptions/orders, add and edit patients, view status of orders, check on delivery status, run reports and view organization/physician/staff settings. After the requested information is processed, you will receive a welcome email within 24 hours with important information.

We look forward to building a long-term relationship with your company and thank you for your business. Please contact your Sales Representative or our Customer Service Department if you have any questions or concerns at 800.995.4363, Option 5.

AnazaoHealth Locations & Hours of Operation:

503A Compounding Pharmacy
5710 Hoover Blvd.
Tampa, FL 33634
Monday – Friday, 8:00 am – 8:30 pm EST

503B FDA-Registered Outsourcing Facility
7465 W. Sunset Road, Ste.1200
Las Vegas, NV 89113
Monday – Friday, 8:00 am – 5:30 pm PST

Phone: 800.995.4363

Option 1 – Pain Management Pharmacy
Option 2 – Nuclear Medicine Pharmacy
Option 3 – Custom Pharmacy
Option 5 – Customer Service
Option 6 – Accounting

Fax Orders:

800.985.4363 – 503A Patient Specific Wellness & Pain Management Pharmacy
800.697.5250 – Nuclear Medicine Pharmacy
800.238.8239 – 503B Office Use Orders Wellness Pharmacy

New Customer Set-Up Form

PRESCRIBER AND BILLING INFORMATION

NAME OF BUSINESS/ PRACTICE:				TODAY'S DATE:	
STREET ADDRESS OF BUSINESS/ PRACTICE:				CITY OF BUSINESS/ PRACTICE:	
STATE OF BUSINESS/ PRACTICE:		ZIP OF BUSINESS/ PRACTICE:		WEBSITE OF BUSINESS/ PRACTICE:	
PHONE OF BUSINESS/ PRACTICE:				FAX OF BUSINESS/ PRACTICE:	
CONTACT PERSON FOR ORDER QUESTIONS:				TITLE OF CONTACT PERSON:	
CELL PHONE/PHONE OF CONTACT PERSON:				EMAIL OF CONTACT PERSON:	
ACCOUNTING CONTACT PERSON:				ACCOUNTING CONTACT EMAIL:	
EMAIL FOR RECEIVING INVOICES:		BUSINESS/PRACTICE SPECIALTY:		ESTIMATED ANNUAL BUSINESS $:	
HOW DID YOU HEAR ABOUT US:				DAYS & HOURS OF BUSINESS /PRACTICE OPERATION:	
TYPE OF ACCOUNT:	*Check all that apply:* ☐ Patient-Specific Wellness ☐ Office-Use Wellness ☐ Pain Management ☐ Nuclear				
ANAZAOHEALTH SALES REP:				CENTRAL FILL PHARMACY:	☐ YES ☐ NO

PRESCRIBER INFORMATION

PRESCRIBER NAME:		CREDENTIALS:	☐ MD ☐ DO ☐ ND ☐ NP ☐ ARNP ☐ PA ☐ OTHER_____		
MEDICAL LICENSE #:		DEA #:		NPI #:	
CELL PHONE/PHONE OF PRESCRIBER:		**EMAIL OF PRESCRIBER:**			
PRESCRIBER NAME:		CREDENTIALS:	☐ MD ☐ DO ☐ ND ☐ NP ☐ ARNP ☐ PA ☐ OTHER_____		
MEDICAL LICENSE #:		DEA #:		NPI #:	
CELL PHONE/PHONE OF PRESCRIBER:		**EMAIL OF PRESCRIBER:**			
PRESCRIBER NAME:		CREDENTIALS:	☐ MD ☐ DO ☐ ND ☐ NP ☐ ARNP ☐ PA ☐ OTHER_____		
MEDICAL LICENSE #:		DEA #:		NPI #:	
CELL PHONE/PHONE OF PRESCRIBER:		**EMAIL OF PRESCRIBER:**			
RAM # (FOR NUCLEAR MEDICINE ACCOUNTS):					

****** Note that all medications are compounded pursuant to the physician's prescription. **********

BILLING INFORMATION

PAYMENT OPTIONS:	☐ VISA ☐ MC ☐ DISC ☐ AMEX	☐ Bill Card listed below ☐ PO# Required	**EMAIL FOR RECEIVING INVOICES:**		
CREDIT CARD* #:			EXPIRATION DATE:		
*BILLING ADDRESS FOR CREDIT CARD **IF DIFFERENT** THEN BUSINESS/PRACTICE ADDRESS ABOVE:*					
STREET, CITY, STATE, ZIP CODE:			CARDHOLDERS SIGNATURE:		

PRESCRIBER & PHARMACY AGREEMENT

By submitting a prescription or order, you acknowledge that you have evaluated commercially available drug product options and determined that this compounded product is clinically necessary for the patient(s) to whom this product will be administered.

1. The person(s) signing this New Customer, Terms & Conditions form warrants that the above information is complete and accurate and hereby agrees to the following terms and conditions:
2. The undersigned agrees to immediately notify AnazaoHealth Corporation of any change in ownership, form or business name of the entity.
3. This document will be as effective in photocopy or fax form as in the original.
4. The undersigned acknowledges that AnazaoHealth Corporation may limit or discontinue credit at its sole discretion and that the continued extension of credit may require additional information from time to time.
5. The undersigned warrants that they have full authority to sign this agreement and obligate the entity hereunder.
6. The undersigned agrees that if all invoices are not paid when due, they will accrue late charges at the rate of 1.5% per month or the maximum rate allowed by law, whichever is less. If it is necessary to take legal action, jurisdiction shall be the State of Florida and the venue shall be Hillsborough County, Florida. The undersigned agrees to reimburse AnazaoHealth Corporation for any attorney fees, court costs or other costs of collection which may be incurred in its efforts to collect any past due debts.
7. A Prialt® Terms and Condition form must be signed and on file prior to any prescription being filled.
8. Compounded items may require an attestation of clinical difference from the prescriber, practitioner administering the preparation or practitioner's representative prior to the order being filled.
9. There is a minimum compounding fee of $34.95 for non-sterile preparations and $39.95 for sterile preparation.

*Credit card will be billed on Monday for previous weeks orders.

_________________________ _________________________
SIGNATURE *DATE* *SIGNATURE* *DATE*

_________________________ _________________________
SIGNATURE *DATE* *SIGNATURE* *DATE*