

New Customer Set-Up (Controlled Product)



INSTRUCTIONS ON FILLING OUT THE FORM

1. Complete, sign, and return the New Customer Set-Up Form along with Billing Information prior to the first order being shipped.
2. **Complete fillable electronic form, including electronic signature.**
3. Provide copies of **Medical Licenses** for each state, and if applicable, copies of **DEA registrations, State Controlled Substance registrations, Business Licenses & Attestation Forms**.
4. The completed New Customer Set-Up Form can be faxed or emailed to:

Fax: 800.985.4363 (Attn: Sales) Email: CustomerService@anazaohealth.com

- Checklist:**
- | | |
|---|--|
| <input type="checkbox"/> Form Completed | <input type="checkbox"/> Copy of DEA Registration |
| <input type="checkbox"/> Form Signed | <input type="checkbox"/> Copy of State Controlled Substance Registration/BNDD/TDDD (if applicable) |
| <input type="checkbox"/> Billing Information Included | <input type="checkbox"/> Copy of Business License (if applicable) |
| <input type="checkbox"/> Copy of Medical License(s) | <input type="checkbox"/> Completed Attestation Form(s) (if applicable) |

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. myAnazao.com is the preferred method for placing an order but fax or phone are also available.

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 3 or 5.

CONTACT INFORMATION & HOURS OF OPERATION

503A Compounding Pharmacy

5710 Hoover Blvd.

Tampa, FL 33634

Monday - Friday, 8:00 am 5:30 pm EST

503A Compounding Pharmacy

5401 Hangar Ct.

Tampa, FL 33634

Monday - Friday, 8:00 am 5:30 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
- Option 3 - 503B Vegas Office-Use Wellness
- Option 4 - General Customer Service
- Option 5 - 503A Tampa Patient-Specific Wellness
- Option 6 - Patient Billing/Customer Invoice
- Option 7 - Hours & Locations
- Option 8 - Prescription Refill
- Option 9 - Vendor Account Payable

Fax:

800.985.4363

- 503A Patient-Specific Wellness & Pain Management Pharmacy
- 800.238.8239**
- 503B Outsourcing Facility Office-Use Wellness

503B Outsourcing Facility Regulatory Department Use Only

Required:

- | | | |
|--|---|---|
| <input type="checkbox"/> Form Completed and Signed | <input type="checkbox"/> DEA Registration | <input type="checkbox"/> Medical License(s) |
|--|---|---|

If Applicable:

- | | | |
|---|--|--|
| <input type="checkbox"/> Business License | <input type="checkbox"/> Attestation Form(s) | <input type="checkbox"/> State Controlled Substance Registration/BNDD/TDDD |
|---|--|--|

Documents reviewed, verified, and site verification performed by:

SIGNATURE

DATE

New Customer Set-Up (Controlled Product)



BUSINESS SPECIALTY/PRACTICE INFORMATION

| | | |
|---|--|---------------|
| NAME OF BUSINESS SPECIALTY/PRACTICE: | PHONE OF BUSINESS SPECIALTY/PRACTICE: | TODAY'S DATE: |
| STREET OF BUSINESS SPECIALTY/PRACTICE: | FAX OF BUSINESS SPECIALTY/PRACTICE: | |
| CITY OF BUSINESS SPECIALTY/PRACTICE: | WEBSITE OF BUSINESS SPECIALTY/PRACTICE: | |
| STATE OF BUSINESS SPECIALTY/PRACTICE: | BUSINESS SPECIALTY: | |
| ZIP OF BUSINESS SPECIALTY/PRACTICE: | DAYS & HOURS OF OPERATION: | |

HOW DID YOU HEAR ABOUT US:

IS THIS A MEDICAL FACILITY: YES NO **IF NO, PLEASE PROVIDE BUSINESS LICENSE**

ESTIMATED ANNUAL VOLUME OF TESTOSTERONE CYPIONATE GSO, TESTOSTERONE HORMONE PELLETS, & NANDROLONE YOU WILL ORDER: QUANTITY: _____ (UNITS)

TYPICAL ORDERING PATTERN FOR 503B CONTROLLED SUBSTANCES: WEEKLY MONTHLY QUARTERLY
 SEMI-ANNUAL YEARLY

HAS THE PRESCRIBER HAD A DEA REGISTRATION OR STATE LICENSE/REGISTRATION SUSPENDED, REVOKED, OR DISCIPLINED WITHIN THE LAST 5 YEARS: NO YES
IF YES, PROVIDE DETAILS BELOW (WHEN, WHY, ETC.)

HAS THE OWNER OR ANY EMPLOYEE OF THE PRACTICE HAD A DEA REGISTRATION OR STATE LICENSE/REGISTRATION SUSPENDED, REVOKED, OR DISCIPLINED WITHIN THE LAST 5 YEARS: NO YES
IF YES, PROVIDE DETAILS BELOW (WHEN, WHY, ETC.)

IF ORDERING ASCORBIC ACID, MIC+CYANO, TESTOSTERONE CYPIONATE GSO, THIAMINE-PYRIDOXINE, ESTRADIOL PELLETS, TESTOSTERONE PELLETS, TESTOSTERONE/ANASTROZOLE PELLETS AND TESTOSTERONE/CHOLESTEROL PELLETS: **PLEASE COMPLETE EACH ATTESTATION FORM(S) FOR 503B PRODUCTS**

TYPE OF ACCOUNT: **CHECK ALL THAT APPLY:** Office-Use (503B) Pain Management (503A)
 Patient-Specific (503A)

REASON FOR ACCOUNT SET UP: **CHECK ONE ONLY:** Start Up Business
 Established Business Changing to AnazaoHealth Corporation as Pharmacy/Supplier
 Established Business Adding AnazaoHealth Corporation as Pharmacy/Supplier

Note all patient-specific orders are compounded pursuant to a prescriber's prescription

BILLING INFORMATION

PAYMENT OPTIONS: Bill Card listed below VISA MC DISC AMEX PO# Required *CREDIT CARD WILL BE BILLED ON MONDAY FOR PREVIOUS WEEKS ORDERS

CREDIT CARD* #: _____ EXP. DATE: _____

NAME ON CARD: _____ CARDHOLDER SIGNATURE: _____

PROVIDE BELOW BILLING ADDRESS FOR CREDIT CARD IF DIFFERENT THAN THE ADDRESS IN SECTION "BUSINESS/PRACTICE INFORMATION"

STREET: _____ CITY: _____ STATE: _____ ZIP: _____

ACCOUNTING & GENERAL INFORMATION

ACCOUNTING CONTACT PERSON: _____ EMAIL OF ACCOUNTING CONTACT PERSON: _____

EMAIL FOR RECEIVING INVOICES: _____ PHONE # OF ACCOUNTING: _____

CONTACT PERSON FOR ORDER QUESTIONS: _____ PHONE/CELL # OF CONTACT PERSON: _____

TITLE OF CONTACT PERSON: _____ EMAIL OF CONTACT PERSON: _____

EMAIL ADDRESS FOR MYANAZAO PORTAL ADMINISTRATOR: _____

ANAZAOHEALTH SALES REP: _____

PROVIDE BELOW REPRESENTATIVES WHO ARE AUTHORIZED TO ORDER PRODUCTS AND ALLOWED TO MAKE CHANGES TO YOUR ACCOUNT:

| | |
|-------|--------|
| NAME: | TITLE: |
| NAME: | TITLE: |
| NAME: | TITLE: |
| NAME: | TITLE: |

PRESCRIBER(S) INFORMATION

| | | | | | | | |
|--|--|---------------------------|--|-------------------------|--|---------------|-------------------|
| 1ST PRESCRIBER NAME: | | | | PHONE/CELL #: | | EMAIL: | |
| NPI #: | | MEDICAL LICENSE #: | | CREDENTIAL: | | STATE: | EXP. DATE: |
| <i>PROVIDE BELOW ADDRESS ASSOCIATED WITH DEA #</i> | | | | DEA #: | | | |
| STREET: | | CITY: | | STATE: | | ZIP: | |
| <i>PROVIDE COLLABORATING PHYSICIAN INFORMATION BELOW (IF APPLICABLE)</i> | | | | | | | |
| NAME (COLLABORATOR): | | | | DEA #: | | | |
| NPI #: | | MEDICAL LICENSE #: | | CREDENTIAL: | | STATE: | EXP. DATE: |
| <i>FOR AL,CT,DE,DC,HI,IA,ID,IL,IN,LA,MA,MD,MI,MO,NJ,NM,NV,OH,OK,PR,RI,SC,SD,UT, & WY PROVIDE BELOW STATE CONTROLLED SUBSTANCE/BNDD OR TDDD #</i> | | | | | | | |
| STATE CONTROLLED SUBSTANCE / BNDD #: | | | | FOR OHIO TDDD #: | | | |
| 2ND PRESCRIBER NAME: | | | | PHONE/CELL #: | | EMAIL: | |
| NPI #: | | MEDICAL LICENSE #: | | CREDENTIAL: | | STATE: | EXP. DATE: |
| <i>PROVIDE BELOW ADDRESS ASSOCIATED WITH DEA #</i> | | | | DEA #: | | | |
| STREET: | | CITY: | | STATE: | | ZIP: | |
| <i>PROVIDE COLLABORATING PHYSICIAN INFORMATION BELOW (IF APPLICABLE)</i> | | | | | | | |
| NAME (COLLABORATOR): | | | | DEA #: | | | |
| NPI #: | | MEDICAL LICENSE #: | | CREDENTIAL: | | STATE: | EXP. DATE: |
| <i>FOR AL,CT,DE,DC,HI,IA,ID,IL,IN,LA,MA,MD,MI,MO,NJ,NM,NV,OH,OK,PR,RI,SC,SD,UT, & WY PROVIDE BELOW STATE CONTROLLED SUBSTANCE/BNDD OR TDDD #</i> | | | | | | | |
| STATE CONTROLLED SUBSTANCE / BNDD #: | | | | FOR OHIO TDDD #: | | | |
| 3RD PRESCRIBER NAME: | | | | PHONE/CELL #: | | EMAIL: | |
| NPI #: | | MEDICAL LICENSE #: | | CREDENTIAL: | | STATE: | EXP. DATE: |
| <i>PROVIDE BELOW ADDRESS ASSOCIATED WITH DEA #</i> | | | | DEA #: | | | |
| STREET: | | CITY: | | STATE: | | ZIP: | |
| <i>PROVIDE COLLABORATING PHYSICIAN INFORMATION BELOW (IF APPLICABLE)</i> | | | | | | | |
| NAME (COLLABORATOR): | | | | DEA #: | | | |
| NPI #: | | MEDICAL LICENSE #: | | CREDENTIAL: | | STATE: | EXP. DATE: |
| <i>FOR AL,CT,DE,DC,HI,IA,ID,IL,IN,LA,MA,MD,MI,MO,NJ,NM,NV,OH,OK,PR,RI,SC,SD,UT, & WY PROVIDE BELOW STATE CONTROLLED SUBSTANCE/BNDD OR TDDD #</i> | | | | | | | |
| STATE CONTROLLED SUBSTANCE / BNDD #: | | | | FOR OHIO TDDD #: | | | |

OWNER/AUTHORIZED REPRESENTATIVE & ANAZAOHEALTH CORPORATION 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 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.

| | | | |
|---------------------------|---------------------------|---------------------------|---------------------------|
| <i>SIGNATURE</i> | <i>SIGNATURE</i> | <i>SIGNATURE</i> | <i>SIGNATURE</i> |
| <i>PRINTED NAME/TITLE</i> | <i>PRINTED NAME/TITLE</i> | <i>PRINTED NAME/TITLE</i> | <i>PRINTED NAME/TITLE</i> |
| <i>DATE</i> | <i>DATE</i> | <i>DATE</i> | <i>DATE</i> |