

## INSTRUCTIONS

- 1 Please select the type of request and complete the appropriate section.
- 2 Provide the **NECESSARY** and/or **APPLICABLE** document(s): **DEA registration (REQUIRED FOR CONTROLLED PRODUCT), medical license for each state, state controlled substance registration, business license, & attestation form(s).**

3 The completed Application or Change Request Form (including this page) can be faxed or emailed to:

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

For 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 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.

## SELECT THE TYPE OF REQUEST

### For NEW Account

Today's Date: \_\_\_\_\_

- Account Ordering Controlled Substances - Complete SECTION 1 ONLY**  
**Provide COPY OF DEA & ensure all the RED-highlighted sections are filled out**
- Account NOT ordering Controlled Substances - Complete SECTION 1 ONLY**

For EXISTING Account ⇨ ACCOUNT #: \_\_\_\_\_ ACCOUNT NAME: \_\_\_\_\_

### Request to ADD a New shipping address

- For Account Ordering CONTROLLED SUBSTANCES - Complete SECTION 1 ONLY**  
**Provide COPY OF DEA & ensure all the RED-highlighted sections are filled out**
- For Account NOT ordering Controlled Substances - Complete SECTION 2A & SECTION 6**

### Request to ADD CONTROLS to an existing NON-CONTROLS account

- Complete SECTION 1 - Provide COPY OF DEA, & ensure all the RED-highlighted sections are filled out**

### Request to REMOVE an Existing shipping address

- Complete SECTION 2B & SECTION 6**

### Request to ADD or REMOVE Prescriber

- Complete SECTION 3A or 3B respectively & SECTION 6**

### Request to ADD or REMOVE Staff Member

- Complete SECTION 4 & SECTION 6**

### Request to Change Business Name

- Complete SECTION 5 & SECTION 6**


# SECTION 1

## BUSINESS INFORMATION

Name of Business:		Business Phone #:	
Business Address:		Business Fax #:	
City:		Business Website:	
State:		Business Specialty:	
Zip:		Days & Hours of Operation:	
How did you hear about us:			

<b>Type of account (check all that apply):</b> <input type="checkbox"/> Office-Use (503B) <input type="checkbox"/> Patient-Specific (503A) <input type="checkbox"/> Pain Management (503A)	<b>Reason for this application (Check one only):</b> <input type="checkbox"/> Start Up Business <input type="checkbox"/> Established Business Changing to AnazaoHealth Corporation as Pharmacy/Supplier <input type="checkbox"/> Established Business Adding AnazaoHealth Corporation as Pharmacy/Supplier <input type="checkbox"/> Updating existing account with AnazaoHealth Corporation
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Is this a medical/commercial facility:  YES  NO **If NO, please provide Business License**

If ordering Ascorbic Acid, MIC+Cyano, Testosterone Cypionate GSO, Thiamine-Pyridoxine, Estradiol Pellets, Testosterone Pellets, Testosterone-Anastrozole Pellets, or Testosterone-Cholesterol Pellets:  **Please fill out each Attestation Form for 503B Products**

**Complete the RED-highlighted sections if you plan to order Controlled Substances**

Provide ESTIMATE of annual volume Testosterone Cypionate GSO, Testosterone Hormone Pellets, & Nandrolone you will order (must be numeric value):	QUANTITY: _____ (UNITS)
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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.)

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

## PRESCRIBER(S) INFORMATION

1 <sup>st</sup> Prescriber Name:	Contact #:	Email:
NPI #:	Medical license #:	Credential:
	State:	Exp. Date:

*Provide below the address associated with the DEA #*

DEA #:	Street:	City:	State:	Zip:
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*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 the State Contolled Substance Registration, BNDD, OR TDDD #*

State Controlled Substance Registration or BNDD #:	FOR OHIO TDDD #:
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*Provide below the collaborating physician information (if applicable)*

Name (Collaborator):	NPI:	DEA #:
Medical license #:	Credential:	State:
		Exp. Date:

2 <sup>nd</sup> Prescriber Name:	Contact #:	Email:
NPI #:	Medical license #:	Credential:
	State:	Exp. Date:

*Provide below the address associated with the DEA #*

DEA #:	Street:	City:	State:	Zip:
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*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 the State Contolled Substance Registration, BNDD, OR TDDD #*

State Controlled Substance Registration or BNDD #:	FOR OHIO TDDD #:
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*Provide below the collaborating physician information (if applicable)*

Name (Collaborator):	NPI:	DEA #:
Medical license #:	Credential:	State:
		Exp. Date:

# SECTION 1 (Continued)

## ACCOUNTING & GENERAL INFORMATION

Accounting contact Person:		Email of accounting contact person:	
Email for receiving invoices:		Phone # of accounting:	
Contact person for ordering 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:	

## BILLING INFORMATION

For billing and payment purposes, please fill out the **Credit Card / ACH Authorization Form** located on the last page of this document. **A 3% administrative Fee will be applied to all credit card payments and billed separately.** Additionally, credit card payments will be billed on Monday for the previous week's orders.

PO# Required

## 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.**

- 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:
- The undersigned agrees to immediately notify AnazaoHealth Corporation of any change in ownership, form, or business name of the entity.
- This document will be as effective in photocopy or fax form as in the original.
- 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.
- The undersigned warrants that they have full authority to sign this agreement and obligate the entity hereunder.
- 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.
- A Prialt® Terms and Condition form must be signed and on file prior to any prescription being filled.
- 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.
- There is a minimum compounding fee of \$34.95 for non-sterile preparations and \$39.95 for sterile preparation.
- A 3% administrative fee will be applied to all credit card payments.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name/Title

\_\_\_\_\_  
Printed Name/Title

\_\_\_\_\_  
Printed Name/Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

# SECTION 2

## 2A. ADD NEW SHIPPING ADDRESS (NON-CONTROLLED PRODUCT ACCOUNT)

Enter NEW Address Below & Prescriber(s) Information:				Days & Hours of Operation:			
Street:		City:		State:		Zip:	
<input type="checkbox"/> The address is in the same state as the current address <input type="checkbox"/> If the address is located in a different state from the current address Then provide a copy of Medical License for that state <input type="checkbox"/> This is a medical/commercial facility <input type="checkbox"/> If this is NOT a medical/commercial facility Then provide a copy of Business License <input type="checkbox"/> For Ohio Only Please provide copy of TDDD #							
Prescriber Name:		Contact #:		Email:			
NPI #:		Medical license #:		Credential:		State:	Exp. Date:
Prescriber Name:		Contact #:		Email:			
NPI #:		Medical license #:		Credential:		State:	Exp. Date:

## 2B. REMOVE EXISTING SHIPPING ADDRESS

Address to remove:	Street:		City:		State:		Zip:	
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# SECTION 3

## 3A. ADD NEW PRESCRIBER

<input type="checkbox"/> For Account NOT procuring Controlled Substances (NON-Controlled Product Account) - Complete black sections below <input type="checkbox"/> For Account ordering Controlled Substances - Complete BOTH black and red sections below What impact will this change have on the Ordering Volume of Controlled Substances (Testosterone Pellets, Testosterone Cypionate & Nandrolone)? <input type="checkbox"/> Increase quantity: _____ (Units/month) <input type="checkbox"/> Decrease quantity: _____ (Units/month) <input type="checkbox"/> Stay the same <input type="checkbox"/> Please provide copy of Prescriber's DEA Registration <input type="checkbox"/> Please provide copy of Medical License <input type="checkbox"/> Please provide copy of State Controlled Substance, BNDD, or TDDD # for the states listed below 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							
Prescriber Name to add:		Contact #:		Email:			
NPI #:		Medical license #:		Credential:		State:	Exp. Date:
Provide below the address associated with the DEA #				DEA #:			
Street:		City:		State:		Zip:	
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 the State Contolled Substance Registration, BNDD, OR TDDD #							
State Controlled Substance Registration or BNDD #:		FOR OHIO TDDD #:					
Provide below the collaborating physician information (if applicable)							
Name (Collaborator):		NPI:		DEA #:			
Medical license #:		Credential:		State:		Exp. Date:	
Please enter the location where you would like to add the new prescriber:							
Street:		City:		State:		Zip:	
Street:		City:		State:		Zip:	

# SECTION 3 (Continued)

3B. REMOVE EXISTING PRESCRIBER		
<input type="checkbox"/> For Account NOT procuring Controlled Substances (NON-Controlled Product Account) - Complete black section below		
<input type="checkbox"/> For Account procuring Controlled Substances - Complete BOTH black and red sections below		
<b>What impact will this change have on the Ordering Volume of Controlled Substances (Testosterone Pellets, Testosterone Cypionate &amp; Nandrolone)?</b>		
<input type="checkbox"/> Increase quantity: _____ (Units/month)	<input type="checkbox"/> Decrease quantity: _____ (Units/month)	<input type="checkbox"/> Stay the same
Prescriber Name to removed:		

# SECTION 4

ADD OR REMOVE STAFF			
Staff Name(s) to add:			
1.	Title:	Email:	
2.	Title:	Email:	
3.	Title:	Email:	
Staff Name(s) to remove:			
1.			
2.			
3.			

# SECTION 5

CHANGE BUSINESS NAME	
Old Business Name:	
Business Name changed to:	

# SECTION 6

REPRESENTATIVE WHO IS AUTHORIZING THIS CHANGE TO THE ACCOUNT:			
Name:		Title:	
Contact #:		Email:	
Signature:		Date:	

## CREDIT CARD / ACH AUTHORIZATION FORM

**CREDIT CARD INFORMATION** - if charging a credit or debit card. **A 3% administrative fee is applied to all Credit Card payments.**

Cardholder Name:

Credit Card Number:

Expiration Date:

Card Type:  Visa  MasterCard  American Express  Discover

\* Please note, you will be contacted via the phone number provided below, for the above credit card CVV, in compliance with PCI standards.

**ACH DEBIT INFORMATION** - if using a bank account. No administrative fee for ACH payments.

Name On Account:

Bank Name:

Routing Number:

Account Number:

Account Type:  Checking  Savings

### BILLING INFORMATION

Name:

AnazaoHealth  
Account #:

Billing Address:

City:

State:

Zip Code:

Phone No.:

Email Address:

#### Recurring Charge

By signing this form, you authorize us to schedule regular charges to your credit card or bank account. You will be charged the amount indicated above each billing period. A receipt for each payment will be provided to you and the charge will appear on your credit card or bank statement. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days before the payment is collected.

This Payment is for:

#### Check the Following Option:

I hereby certify that I am the holder of the credit card and/or bank account detailed above and will not dispute the payments with my bank or credit card issuer, provided the transactions comply with the terms specified in this authorization for

Authorized/Cardholder Signature

Name

Date



503A Patient-Specific Pharmacy  
FDA-Registered 503B Outsourcing Facility



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Las Vegas, NV 89113



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