New Application or Account Change Request

AnazaoHealth®

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:			

Type of account *(check all that apply):*

- ☐ Office-Use (503B)
- ☐ Patient-Specific (503A)
- ☐ Pain Management (503A)

Reason for this application *(Check one only)* :

- ☐ Start Up Business
- ☐ Established Business Changing to AnazaoHealth Corporation as Pharmacy/Supplier
- ☐ Established Business Adding AnazaoHealth Corporation as Pharmacy/Supplier
- ☐ Updating existing account with AnazaoHealth Corporation

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)**
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

1st Prescriber Name:			**Contact #:**		**Email:**				
NPI #:		**Medical license #:**		**Credential:**		**State:**		**Exp. Date:**	
Provide below the address asscociated 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:**		

2nd Prescriber Name:			**Contact #:**		**Email:**				
NPI #:		**Medical license #:**		**Credential:**		**State:**		**Exp. Date:**	
Provide below the address asscociated 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:**		

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.

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.
10. 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:	

☐ The address is in the same state as the current address

☐ If the address is located in a different state from the current address

Then provide a copy of Medical License for that state

☐ This is a medical/commercial facility

☐ If this is NOT a medical/commercial facility

Then provide a copy of Business License

☐ 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:	

SECTION 3

3A. ADD NEW PRESCRIBER

☐ For Account NOT procuring Controlled Substances (NON-Controlled Product Account) - Complete black sections below

☐ 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)?

☐ Increase quanity: _____ (Units/month) ☐ Decrease quantity: _____ (Units/month) ☐ Stay the same

☐ Please provide copy of Prescriber's DEA Registration

☐ Please provide copy of Medical License

☐ 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 asscociated 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					
☐ For Account NOT procuring Controlled Substances (NON-Controlled Product Account) - Complete black section below					
☐ For Account procuring 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)?					
☐ Increase quanity: _____ (Units/month)		☐ Decrease quantity: _____ (Units/month)		☐ 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:***	

AnazaoHealth®

Clinical Difference Determination

In compliance with Section 503B(a)(S) of the Federal Food, Drug, and Cosmetic Act, and the current FDA guidance interpreting this provision,[1] we are requiring a "clinical difference determination" that corresponds to specific compounded preparations that contain a component of an FDA-approved drug:

Preparation Description: Ascorbic Acid 500 mg/ml preservative free or preserved injection in 10 and 30 ml Vials

Clinical Difference Determination:
(Please check the box next to all statements below that apply or fill in a unique "clinical difference determination)"

☐ In my professional judgement: the use of the above indicated compounded drug preparation that has one or more variations in: active ingredient(s), route of administration, dosage form, dosage strength, and excipient(s) from comparable manufactured drug products provides clinical and safety benefits for patients who require these formulations.

☐ In my professional judgment, the use of this product is clinically necessary for patients who have reactions or sensitivity to Ascorbic Acid that is synthetic or sourced from corn, similar to the FDA-approved product.

☐ In my professional judgment and experience, the commercially FDA-approved product causes pain, inflammation and similar problems at the injection site for some patients, which results in patient compliance and adherence issues to prescribed or medically necessary treatment regimens.

☐ Other: _____

_____

In signing this document, I hereby attest that I am the practitioner who will administer the compounded preparation(s) listed above. Additionally, in signing this document, I hereby attest that the compounded preparation(s) listed above will only be administered to patients for whom the practitioner determines will produce a clinical difference from the comparable approved drug product, as described more fully above.

Please complete and sign the section below as acknowledgement and confirmation of the attestations corresponding to above indicated preparation(s).

Facility Name: _____

Physician Name: _____

Title: _____

Physician Signature: _____ **Date:** _____

☐ By checking this box, I authorize AnazaoHealth to do a yearly renewal on all of the Attestation forms that are on file.

[1]Food and Drug Administration, Guidance for Industry*: Compounded Drug Products That Are Essentially Copies of Approved Drug Products Under Section 503B of the Federal Food, Drug, and Cosmetic Act,* January 2018, *available at* https://www.fda.gov/regulatory-information/search-fda-guidance-documents/compounded-drug-products-are-essentially-copies-approved-drug-products-under-section-503b-federal

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Preparation Description: B1/B6 20mg, 100mg/ml injection in a 30 ml Amber Vial

Clinical Difference Determination:
(Please check the box next to all statements below that apply or fill in a unique "clinical difference determination)"

☐ In my professional judgement: the use of the above indicated compounded drug preparation that has one or more variations in: active ingredient(s), route of administration, dosage form, dosage strength, and excipient(s) from comparable manufactured drug products provides clinical and safety benefits for patients who require these formulations.

☐ In my professional judgment, the use of this product is clinically necessary for patients who have reactions or sensitivity to Chorobutanol utilized as the preservative in the commercially available product.

☐ In my professional judgment and experience, the FDA-approved products given separately, cause a higher risk of pain, inflammation, and similar problems at the injection site for some patients, which results in patient compliance and adherence issues to prescribed or medically necessary treatment regimens.

☐ Other: _____

_____

In signing this document, I hereby attest that I am the practitioner who will administer the compounded preparation(s) listed above. Additionally, in signing this document, I hereby attest that the compounded preparation(s) listed above will only be administered to patients for whom the practitioner determines will produce a clinical difference from the comparable approved drug product, as described more fully above.

Please complete and sign the section below as acknowledgement and confirmation of the attestations corresponding to above indicated preparation(s).

Facility Name: _____

Physician Name: _____

Title: _____

Physician Signature: _____ **Date:** _____

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Preparation Description: Estradiol Implantable Pellets: 6 mg - 25 mg (all strengths)

Clinical Difference Determination:
(Please check the box next to all statements below that apply or fill in a unique "clinical difference determination)"

☐ In my professional judgement: the use of the above indicated compounded drug preparation that has one or more variations in: active ingredient(s), route of administration, dosage form, dosage strength, and excipient(s) from comparable manufactured drug products provides clinical and safety benefits for patients who require these formulations.

☐ In my professional judgment and experience, the use of the above indicated compounded drug preparation is clinically necessary because there is no commercially available dosage form like the compounded drug product above.

☐ In my professional judgment and experience, the use of the above indicated compounded drug preparation is clinically necessary because the use of the commercially available product in dosage form provided does not provide the same clinical characteristics as the compounded drug product above.

☐ In my professional judgment and experience, the use of any commercial drug product over the compounded drug product above could result in patient compliance and adherence issues posing unnecessary risk to the patient for prescribed and medically necessary treatment regimens.

☐ Other: _____

_____

In signing this document, I hereby attest that I am the practitioner who will administer the compounded preparation(s) listed above. Additionally, in signing this document, I hereby attest that the compounded preparation(s) listed above will only be administered to patients for whom the practitioner determines will produce a clinical difference from the comparable approved drug product, as described more fully above.

Please complete and sign the section below as acknowledgement and confirmation of the attestations corresponding to above indicated preparation(s).

Facility Name: _____

Physician Name: _____

Title: _____

Physician Signature: _____ **Date:** _____

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Preparation Description: Methionine (L), Inositol, Choline with Cyanocobalamin 25/50/50/1 mg/mL

Clinical Difference Determination:
(Please check the box next to all statements below that apply or fill in a unique "clinical difference determination)"

☐ In my professional judgement: the use of the above indicated compounded drug preparation that has one or more variations in: active ingredient(s), route of administration, dosage form, dosage strength, and excipient(s) from comparable manufactured drug products provides clinical and safety benefits for patients who require these formulations.

☐ In my professional judgment, the use of this product is clinically necessary for patients who have reactions or sensitivity to one or more of the ingredients in the commercially available product.

☐ In my professional judgment and experience, there is only one individual component available commercially that is part of this product, and I could not achieve the equivalent of this product utilizing separate commercially available products.

☐ Other: _____

_____

In signing this document, I hereby attest that I am the practitioner who will administer the compounded preparation(s) listed above. Additionally, in signing this document, I hereby attest that the compounded preparation(s) listed above will only be administered to patients for whom the practitioner determines will produce a clinical difference from the comparable approved drug product, as described more fully above.

Please complete and sign the section below as acknowledgement and confirmation of the attestations corresponding to above indicated preparation(s).

Facility Name: _____

Physician Name: _____

Title: _____

Physician Signature: _____ **Date:** _____

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Clinical Difference Determination

In compliance with Section 503B(a)(S) of the Federal Food, Drug, and Cosmetic Act, and the current FDA guidance interpreting this provision,[1] we are requiring a "clinical difference determination" that corresponds to specific compounded preparations that contain a component of an FDA-approved drug:

Preparation Description: Testosterone Cypionate 200 mg/ml in grapeseed oil (GSO) or medium chain triglycerides (MCT) in 5 ml, 10 ml, or 30 ml amber vial.

Clinical Difference Determination:
(Please check the box next to all statements below that apply or fill in a unique "clinical difference determination)"

☐ In my professional judgement: the use of the above indicated compounded drug preparation that has one or more variations in: active ingredient(s), route of administration, dosage form, dosage strength, and excipient(s) from comparable manufactured drug products provides clinical and safety benefits for patients who require these formulations.

☐ In my professional judgment, the use of this product is clinically necessary for patients who have reactions or sensitivity to cottonseed oil used in the commercially available product.

☐ In my professional judgment and experience, the commercially available product causes pain, inflammation, and similar problems at the injection site for some patients, which results in patient compliance and adherence issues to prescribed or medically necessary treatment regimens.

☐ Other: _____

_____

In signing this document, I hereby attest that I am the practitioner who will administer the compounded preparation(s) listed above. Additionally, in signing this document, I hereby attest that the compounded preparation(s) listed above will only be administered to patients for whom the practitioner determines will produce a clinical difference from the comparable approved drug product, as described more fully above.

Please complete and sign the section below as acknowledgement and confirmation of the attestations corresponding to above indicated preparation(s).

Facility Name: _____

Physician Name: _____

Title: _____

Physician Signature: _____ **Date:** _____

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Clinical Difference Determination

In compliance with Section 503B(a)(S) of the Federal Food, Drug, and Cosmetic Act, and the current FDA guidance interpreting this provision,[1] we are requiring a "clinical difference determination" that corresponds to specific compounded preparations that contain a component of an FDA-approved drug:

Preparation Description: Testosterone Implantable Pellets: 12.5 mg - 200 mg (all strengths)

Clinical Difference Determination:
(Please check the box next to all statements below that apply or fill in a unique "clinical difference determination)"

☐ In my professional judgement: the use of the above indicated compounded drug preparation that has one or more variations in: active ingredient(s), route of administration, dosage form, dosage strength, and excipient(s) from comparable manufactured drug products provides clinical and safety benefits for patients who require these formulations.

☐ In my professional judgment and experience, the use of the above indicated compounded drug preparation is clinically necessary to provide the appropriate dosing based on treatment protocols that cannot be met by the commercially available product.

☐ In my professional judgment and experience, the use of the above indicated compounded drug preparation is clinically necessary because the use of the commercially available product in dosing amounts necessary for the patient's clinical needs and associated treatment protocol will result in unnecessary risk to the patient and/or result in patient compliance and adherence issues to prescribed or medically necessary treatment regimens.

☐ Other: _____

_____

In signing this document, I hereby attest that I am the practitioner who will administer the compounded preparation(s) listed above. Additionally, in signing this document, I hereby attest that the compounded preparation(s) listed above will only be administered to patients for whom the practitioner determines will produce a clinical difference from the comparable approved drug product, as described more fully above.

Please complete and sign the section below as acknowledgement and confirmation of the attestations corresponding to above indicated preparation(s).

Facility Name: _____

Physician Name: _____

Title: _____

Physician Signature: _____ **Date:** _____

☐ By checking this box, I authorize AnazaoHealth to do a yearly renewal on all of the Attestation forms that are on file.

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AnazaoHealth®

Clinical Difference Determination

In compliance with Section 503B(a)(S) of the Federal Food, Drug, and Cosmetic Act, and the current FDA guidance interpreting this provision,[1] we are requiring a "clinical need statement" that corresponds to specific compounded preparations that contain a component of an FDA-approved drug:

Preparation Description: Testosterone Pellets with Cholesterol 87.5 mg, - 200 mg (all strengths)

Clinical Difference Determination:
(Please check the box next to all statements below that apply or fill in a unique "clinical difference determination)"

☐ In my professional judgement: the use of the above indicated compounded drug preparation that has one or more variations in: active ingredient(s), route of administration, dosage form, dosage strength, and excipient(s) from comparable manufactured drug products provides clinical and safety benefits for patients who require these formulations.

☐ In my professional judgment and experience, the use of the above indicated compounded drug preparation is clinically necessary to provide the appropriate dosing based on treatment protocols that cannot be met by the commercially available product.

☐ In my professional judgment and experience, the use of the above indicated compounded drug preparation is clinically necessary because the commercially available product labeling and directions for use restrict my ability to provide appropriate treatment and/or dosing to my patient(s).

☐ In my professional judgment and experience, the use of the above indicated compounded drug preparation is clinically necessary because the use of the commercially available product in dosing amounts necessary for the patient's clinical needs and associated treatment protocol will result in unnecessary risk to the patient and/or result in patient compliance and adherence issues to prescribed or medically necessary treatment regimens.

☐ Other: _____

_____

In signing this document, I hereby attest that I am the practitioner who will administer the compounded preparation(s) listed above. Additionally, in signing this document, I hereby attest that the compounded preparation(s) listed above will only be administered to patients for whom the practitioner determines will produce a clinical difference from the comparable approved drug product, as described more fully above.

Please complete and sign the section below as acknowledgement and confirmation of the attestations corresponding to above indicated preparation(s).

Facility Name: _____

Physician Name: _____

Title: _____

Physician Signature: _____ **Date:** _____

☐ By checking this box, I authorize AnazaoHealth to do a yearly renewal on all of the Attestation forms that are on file.

[1]Food and Drug Administration, Guidance for Industry*: Compounded Drug Products That Are Essentially Copies of Approved Drug Products Under Section 503B of the Federal Food, Drug, and Cosmetic Act,* January 2018, *available at* https://www.fda.gov/regulatory-information/search-fda-guidance-documents/compounded-drug-products-are-essentially-copies-approved-drug-products-under-section-503b-federal

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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 adminitrative 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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