12
12A
NEVADA STATE BOARD OF PHARMACY  
431 W Plumb Lane – Reno, NV 89509  
APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE  
$500.00 Fee made payable to: Nevada State Board of Pharmacy  
(non-refundable and not transferable money order or cashier's check only)  
Application must be printed legibly or typed  
Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

☑ New Pharmacy or ☐ Ownership Change  (Provide current license number if making changes: PH___)  
Check box below for type of ownership and complete all required forms.  
☐ Publicly Traded Corporation – Pages 1,2,3,7  ☑ Partnership - Pages 1,2,5,7  
☐ Non Publicly Traded Corporation – Pages 1,2,4,7  ☑ Sole Owner – Pages 1,2,6,7

GENERAL INFORMATION to be completed by all types of ownership  
Pharmacy Name: AZBDBR, LLC dba AvasaRx Pharmacy

Physical Address: 816 N. 6th Ave.  
Mailing Address: 816 N. 6th Ave.

City: Phoenix  
State: AZ  
Zip Code: 85003

Telephone: 480-900-7450  
Fax: 833 437-2301

Toll Free Number: 844-482-2005  (Required per NAC 639.708)  
E-mail: info@avasarx.com  
Website: AVASARX.COM

Managing Pharmacist: Ronak Modi  
License Number: S023110

<table>
<thead>
<tr>
<th>TYPE OF PHARMACY</th>
<th>AND</th>
<th>SERVICES PROVIDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Yes/No</td>
<td>☐ Yes/No</td>
<td>☑ Retail</td>
</tr>
<tr>
<td>☐ Retail</td>
<td>☑ Off-site Cognitive Services</td>
<td></td>
</tr>
<tr>
<td>☐ Hospital (# beds ___)</td>
<td>☑ Parenteral **</td>
<td></td>
</tr>
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<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>☑ Community</td>
<td>☑ Long Term Care</td>
<td></td>
</tr>
<tr>
<td>☑ Other: Independent</td>
<td>☑ Sterile Compounding **</td>
<td></td>
</tr>
<tr>
<td>☑ Other Services: Home Infusion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting.**
APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)?  Yes ☐ No ☑

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration?  Yes ☐ No ☑

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry?  Yes ☐ No ☑

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances?  Yes ☐ No ☑

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)?  Yes ☐ No ☑

If the answer to question 1 through 5 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized pharmacy may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.

Original Signature of Person Authorized to Submit Application, no copies or stamps

CHAITANYA GADDE
Print Name of Authorized Person

Date

Page 2
APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP

General _____ Limited L _____

Partnership Name: AZBDBR, LLC

Mailing Address: 816 N. 6th Ave.

City: Phoenix State: AZ Zip Code: 85003

Telephone Number: 480-900-7450 Fax Number: 833-437-2301

Contact Person: Ronak Modi

List each partner and identify whether (G)eneral or (L)imited partner and percentage of ownership
Use separate sheet if necessary

<table>
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<td>51%</td>
</tr>
<tr>
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<td>49%</td>
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List names of 4 largest partners and percentage of ownership:

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<tr>
<td></td>
<td></td>
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<tr>
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<td></td>
</tr>
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List any physician shareholders and percentage of ownership.

<table>
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<th>Name</th>
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Hours of Operation for the pharmacy:

Monday thru Friday: 9:00 am - 5:00 pm MST

Saturday: x am - x pm

Sunday: x am - x pm 24 Hours ON CALL

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: ______________________
STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, ________________ CHAITANYA GADDE
Responsible Person of ________________ AZBDBR, LLC dba AvasaRx Pharmacy
hereby acknowledge and understand that in addition to the corporation's, any owner(s),
shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law
that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s)
or partner(s) may be named in any action taken by the Nevada State Board of Pharmacy against a
pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s)
or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision
of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

[Signature]
Original Signature of Person Authorized to Submit Application, no copies or stamps

_________________________ CHAITANYA GADDE
Print Name of Authorized Person

_________________________ 11/1/2018
Date

Page 8
AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Delaware   )
New Castle County   ) ss.

I, Chaitanya Gadde, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the Authorized Signer for AZBDBR, LLC dba Avasa Rx (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy’s behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy’s application for a Nevada Out-of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, Chaitanya Gadde, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Name

SUBSCRIBED AND SWORN TO before me, a notary public this 1st day of November, 2018.

[Notary Public Signature]

Name

[Notary Public Seal]
OWNERS

- AZ Hemophilia Assoc. 826 N. 5th Ave, Phoenix, AZ 85003 602-955-3947
- Bio Tek reMEDys, Inc. 2 Penns Way, Suite #404,
  New Castle, DE 19720 302-544-5138

Pharmacist

- Ronak Modi  W. Portland Street, Phoenix, AZ 85003 S023110

Pharmacy Technician

- Shalomith Adina David 7 N. 47th Dr., Phoenix, AZ 85031 10049494

AvasaRX
816 N. 6th Ave. Phoenix, AZ 85003
Tel: 844-482-2005
Fax: 833-437-2301
www.avasarx.com
Resident Pharmacy/Limited Service
Retail

PERMIT NO
Y007409
AZBDBR, LLC
816 N 6TH AVE
PHOENIX, AZ 85003

EXPIRES
10/31/2019
AvantRx Pharmacy
816 N 6TH AVENUE
PHOENIX, AZ 85003

EXECUTIVE DIRECTOR

ARIZONA STATE BOARD OF PHARMACY

WALLET CARD

NAME: AZBDBR, LLC
LICENSE NUMBER: Y007409
EXPIRES: 10/31/2019

http://www.azpharmacy.gov

Important Information
LICENSE HOLDER (pharmacist, intern, technician, technician-trainee)
Holder of this license number, printed above, is authorized in accordance with A.A.C. R4-23-201(A), A.A.C. R4-23-301(A) or A.A.C R4-23-1101(A), to
perform the duties associated within their profession. By holding this license, the licensee agrees to comply with state & federal law.
You are required by law to notify the Board of any name address and/or employment change within 10 business days.

PERMIT HOLDER (pharmacy, non-prescription retailer (OTC), wholesale, manufacturer, CMG, DME)
Holder of this permit number, printed above, is authorized to conduct business according to the classification specified in A.R.S. § 32-1908(A); A.A.C. R4-23-
01 and A.A.C. R4-23-607. By holding this permit, the permittee agrees to comply with state & federal law.
In-state pharmacy, wholesaler & manufacture permit holder(s) who plan to remodel or move locations, must submit a change-of-location/remodel form within 30
days prior to move/remodel. In-state non-prescription (OTC), compressed medical gas (CMG) & DME providers who plan to move locations must notify the
Board within 10 business days of move.
Out-of-State permit holders must notify the Board of location changes, in writing, within 10 business days of move. A revised copy of your state permit shall be
submitted to the Board, when available.
Permits are non-transferable. Ownership changes of more than 30% require that a new application be submitted to the Board.

* Your license must be available for inspection during business hours.
* Permit holder(s) must display permit in the location to which it is issued.
* Please note it is your responsibility to keep this license/permit current.
12B
NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509
APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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Check box below for type of ownership and complete all required forms.
Publicly Traded Corporation – Pages 1,2,3,7  x Partnership - Pages 1,2,5,7
Non Publicly Traded Corporation – Pages 1,2,4,7  x Sole Owner – Pages 1,2,6,7

GENERAL INFORMATION to be completed by all types of ownership
Pharmacy Name: Premier Specialty Infusion, LLC
Physical Address: 2401 Hassell Rd Ste 1525
Mailing Address: 2401 Hassell Rd. Ste 1525
City: Hoffman Estates  State: ILLINOIS  Zip Code: 60169
Telephone: 800-783-9655  Fax: 877-770-4179
Toll Free Number: 800-783-9655 (Required per NAC 639.708)
E-mail: scott.luckow@psinfusion.com Website: www.psinfusion.com
Managing Pharmacist: Scott Luckow License Number: 51.041005

<table>
<thead>
<tr>
<th>TYPE OF PHARMACY AND SERVICES PROVIDED</th>
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<tbody>
<tr>
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<tr>
<td>□ Retail</td>
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</tr>
<tr>
<td>□ Ambulatory Surgery Center</td>
</tr>
<tr>
<td>□ Community</td>
</tr>
<tr>
<td>□ Other: __________________</td>
</tr>
<tr>
<td>All boxes must be checked</td>
</tr>
<tr>
<td>For the application to be complete</td>
</tr>
<tr>
<td>□ Other Services: _____________</td>
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</table>

**If you check “yes” on any of these types of services, you will be required to make an appearance at the board meeting.
APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)?
   Yes □ No □

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration?
   Yes □ No □

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry?
   Yes □ No □

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances?
   Yes □ No □

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)?
   Yes □ No □

If the answer to question 1 through 5 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized pharmacy may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Scott Luckarew ____________________________ 10/23/18
Print Name of Authorized Person Date

Page 2
APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP

General   Limited ✓

Partnership Name: Premier Specialty Infusion, LLC
Mailing Address: 2401 Hassell Rd Ste 1525
City: Hoffman Estates State: IL Zip Code: 60119
Telephone Number: 800-783-9655 Fax Number: 877-770-4179
Contact Person: Scott Luckow

List each partner and identify whether (G)eneral or (L)imited partner and percentage of ownership
Use separate sheet if necessary

<table>
<thead>
<tr>
<th>Name</th>
<th>G or L</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambreen Yafri</td>
<td>L</td>
<td>97%</td>
</tr>
<tr>
<td>Scott Luckow</td>
<td>L</td>
<td>3%</td>
</tr>
</tbody>
</table>

List names of 4 largest partners and percentage of ownership:

Name: N/A %: 

Name: %: 

Name: %: 

Name: %: 

List any physician shareholders and percentage of ownership.

Name: N/A %: 

Name: %: 

Name: %: 

Name: %: 

Hours of Operation for the pharmacy:

Monday thru Friday 8:00 am - 5:00 pm
Sunday 24 am 7 by phone
Saturday 24 am 7 pm by phone
24 Hours 24 by phone

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A
APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A SOLE OWNER. All information relates to the person listed as the owner.

Owner's Name: N/A

Business Name: ______________________________

Current Business Address: ______________________________

City: __________________ State: _______ Zip Code: ______________

Telephone: __________________ Fax: __________________

List any physician shareholders and percentage of ownership.

Name: N/A %: ______

Name: ______________________ %: ______

Name: ______________________ %: ______

Name: ______________________ %: ______

Hours of Operation for the pharmacy:

Monday thru Friday N/A am _____ pm Saturday N/A am _____ pm

Sunday N/A am _____ pm 24 Hours N/A

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A
STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

1. Scott Luckow
Responsible Person of Premier Specialty Infusion, LLC
hereby acknowledge and understand that in addition to the corporation’s, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation’s, any owner(s), shareholder(s) or partner(s) may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation’s, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Scott Luckow
Print Name of Authorized Person

10/23/18
Date
Include with the Application for Authority to Dispense Drugs

Practitioner Dispensing
Controlled Substance Waiver Form

Each dispensing practitioner must complete this form. Do not submit for a group.

Print Name: Premier Specialty Infusion LLC

Address: 2401 Hassell Rd Ste. 1535

City: Hoffman Estates State: IL Zip: 60149

Telephone: 800-783-9165

☐ I will be dispensing controlled substances at the address listed above and I understand that I am required and submit data to the Prescription Controlled Substance Abuse Prevention Task Force weekly as required by NAC 639.745 [1(f)].

☒ I will not be dispensing controlled substances at the address listed above. If I choose to dispense controlled substances in the future, I must contact the Nevada State Board of Pharmacy to modify my license.

By signing and dating this waiver form, I certify that the information provided is true.

Original Signature of Dispensing Practitioner

Date 10/23/18
AFFIDAVIT for Out-of-State Pharmacy License

STATE OF ILLINOIS  

KANE COUNTY  

AILEEN M WARREN  
Official Seal  
Notary Public – State of Illinois  
My Commission Expires Jan 25, 2021

1. Scott Luckow, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the Pharmacist In Charge for Premier Specialty Infusion (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy’s behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy’s application for a Nevada Out-of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, Scott Luckow, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Name

SUBSCRIBED AND SWORN TO before me, a notary public this 23 day of October, 2018.

AILEEN M WARREN  
NOTARY PUBLIC  
Official Seal  
Notary Public – State of Illinois  
My Commission Expires Jan 25, 2021
To Whom It May Concern:

Below is a list containing the Name, Date of Birth, and Address of All Corporate Officers, Partners or Owner(s):

**Scott Luckow**
Pharmacy Manager, PIC, Owner
W437 Bode Rd
Elgin, IL 60120
DOB: 5

**Ambreen Jafri**
Pharmacy Owner, Partner
Lake Adalyn Drive
South Barrington, IL 60010
DOB: 

Thank you,

Premier Specialty Infusion
2401 W Hassell Rd, Suite 1525
Hoffman Estate, IL 60169
To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that PREMIER SPECIALTY INFUSION, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MARCH 06, 2017, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 8TH day of NOVEMBER A.D. 2018.

Jesse White
SECRETARY OF STATE
To Whom It May Concern,

We are pursuing an out of state pharmacy license and need to request an Illinois Certification of Licensure for our Pharmacy.

Premier Specialty Infusion LLC
2401 Hassell Rd. Ste 1525
Hoffman Estates, IL 60169

License#: 054.020273 - Active
Issued: 04/20/2017
Expires: 03/31/2020
Method of Licensure: Paper
Disciplinary Action: N

Please send the above Illinois Certification of Licensure to:

Nevada State Board of Pharmacy
431 W Plum Lane
Reno, NV 89509

Thank you,

Aileen Warren, PharmD, RPh
Director Of Operations
Aileen.warren@psinfusion.com
800-783-9655

2401 West Hassell Road Suite 1525
Hoffman Estates IL 60169

800.783.9655
877.770.4179
For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 4052203
**NEVADA STATE BOARD OF PHARMACY**  
431 W Plumb Lane – Reno, NV 89509  
**APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE**

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<td>Sole Owner – Pages 1,2,6,7</td>
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</table>

**GENERAL INFORMATION to be completed by all types of ownership**

- **Pharmacy Name:** Soleo Health Inc.  
- **Physical Address:** 10210 Werch Drive, Suite 202  
- **Mailing Address:** Same  
- **City:** Woodridge  
- **State:** IL  
- **Zip Code:** 60517-4809  
- **Telephone:** (630) 589-8054  
- **Fax:** (877) 393-1616  
- **Toll Free Number:** (844) 575-1515  
- **E-mail:** licensee@soleohealth.com  
- **Website:** www.soleohealth.com  
- **Managing Pharmacist:** Jason Howard, PharmD  
- **License Number:** 051.293255

**TYPE OF PHARMACY AND SERVICES PROVIDED**

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</tr>
<tr>
<td>☒ Mail Service Sterile Compounding **</td>
<td>☒</td>
</tr>
<tr>
<td>☐ Other Services: IVIG, Factor</td>
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</tr>
</tbody>
</table>

**If you check “yes” on any of these types of services, you will be required to make an appearance at the board meeting,**
APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)?  Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☒ No ☐

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☒

If the answer to question 1 through 5 is “yes”, a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized pharmacy may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.

Original Signature of Person Authorized to Submit Application, no copies or stamps

John Ginzler ___________________________ January 30, 2019
Print Name of Authorized Person Date

Board Use Only Date Processed: ____________ Amount: $0000
APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: NA

Mailing Address: 11 Trafalgar Square, Suite 101


Telephone: (833) 765-3648 Fax: (603) 718-3624

Contact Person: Christine Belanger

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?
   a) Soleo Health Holdings, Inc. 100%
      Name Address
   b) Name Address
   c) Name Address
   d) Name Address

2) Provide the number of shares issued by the corporation. 100

3) What was the price paid per share? $0.01/share par value

4) What date did the corporation actually receive the cash assets? 2/14/2014

5) Provide a copy of the corporation’s stock register evidencing the above information

List any physician shareholders and percentage of ownership.

Name: N/A %: 

Name: N/A %: 

Hours of Operation for the pharmacy:

Monday thru Friday 8:00 am 5:00 pm Saturday On call am pm

Sunday On call am pm 24 Hours 24/7

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A
STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, John Ginzler, Responsible Person of Soleo Health Inc., hereby acknowledge and understand that in addition to the corporation’s, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation’s, any owner(s), shareholder(s) or partner(s) may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation’s, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Original Signature of Person Authorized to Submit Application, no copies or stamps

John Ginzler
Print Name of Authorized Person

January 30, 2019
Date
AFFIDAVIT for Out-of-State Pharmacy License

STATE OF ______New Hampshire_________ )
) ss.

Hillsborough______COUNTY________ )

I, __John Ginzler______________________, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the __Chief Financial Officer________ for ______Soleo Health Inc.___________ (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy’s behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy’s application for a Nevada Out-of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, __John Ginzler____________, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

SUBSCRIBED AND SWORN TO
before me, a notary public this
30thday of ______January_____, 2019____.

___________________________
Name

___________________________
NOTARY PUBLIC

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "SOLEO HEALTH INC." WAS INCORPORATED ON THE TWENTY-FOURTH DAY OF FEBRUARY, A.D. 2014.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

5486590 8300
SR# 20182683263
You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 202511191
Date: 04-13-18
# Lookup Detail View

## Contact Information

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<thead>
<tr>
<th>Name</th>
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<th>DBA</th>
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<tbody>
<tr>
<td>SOLEO HEALTH INC</td>
<td>Woodridge, IL 60517</td>
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## License Information

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<th>Description</th>
<th>Status</th>
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<th>Effective Date</th>
<th>Expiration Date</th>
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<td>LICENSED PHARMACY</td>
<td>ACTIVE</td>
<td>11/14/2018</td>
<td>11/14/2018</td>
<td>03/31/2020</td>
<td>N</td>
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</table>

Generated on: 1/29/2019 12:37:22 PM
State of Illinois
Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSE NO.
054.020894
051.293255

EXPIRES:
03/31/2020

LICENSED PHARMACY

COMMUNITY

SOLEO HEALTH INC
JASON HOWARD
10210 WERCH DR STE 202
WOODRIDGE, IL 60517-4814

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

134396503

For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 4169695
State of Illinois
Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSE NO. 051.293255

REGSTERED PHARMACIST

JASON R HOWARD
14620 MEADOW LN
PLAINFIELD, IL 60544

EXPRES: 03/31/2020

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

For future reference, IDFPR is now providing each person/business a unique identification number, ‘Access ID’, which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 375123
Soleo Health
Sharon Hill, PA

has been Accredited by

The Joint Commission
Which has surveyed this organization and found it to meet the requirements for the
Home Care Accreditation Program

August 25, 2018
Accreditation is customarily valid for up to 36 months.

Craig W. Jones, PH.D.
Chair, Board of Commissioners

ID #574329
Print/Reprint Date: 10/19/2018

Mark A. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-594-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.