9A
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: BriovaRx Infusion Services 401, LLC.  
Physical Address: 4610 Northgate Blvd., Suite 130, Sacramento, CA 95834  
Mailing Address: 15529 College Blvd.  
City: Lanexa  
State: KS  
Zip Code: 66219  
Telephone: (916) 648-0124  
Fax: (844) 425-0128  
Toll Free Number: (877) 698-5415 (Required per NAC 639.708)  
E-mail: orxpharmacy@optum.com  
Website: BriovaRxInfusionServices.com  
Managing Pharmacist: Ramona Moenter  
License Number: PHY53890

TYPE OF PHARMACY AND SERVICES PROVIDED

<table>
<thead>
<tr>
<th>Yes/No</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Retail</td>
<td>☐ Off-site Cognitive Services</td>
</tr>
<tr>
<td>☐ Hospital (# beds ___)</td>
<td>☐ Parenteral **</td>
</tr>
<tr>
<td>☒ Internet</td>
<td>☐ Parenteral (outpatient)</td>
</tr>
<tr>
<td>☐ Nuclear</td>
<td>☐ Outpatient/Discharge</td>
</tr>
<tr>
<td>☒ Ambulatory Surgery Center</td>
<td>☐ Mail Service</td>
</tr>
<tr>
<td>☒ Community</td>
<td>☐ Long Term Care</td>
</tr>
<tr>
<td>☒ Other: ________________</td>
<td>☒ Sterile Compounding **</td>
</tr>
<tr>
<td></td>
<td>☐ Non Sterile Compounding</td>
</tr>
<tr>
<td></td>
<td>☐ Mail Service Sterile Compounding **</td>
</tr>
<tr>
<td></td>
<td>☐ Other Services: ________________</td>
</tr>
</tbody>
</table>

All boxes must be checked  
For the application to be complete

**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

Edward P. Kramm

Print Name of Authorized Person

Date

Page 2

Board Use Only

Date Processed: ____________________

Amount: $5,000
APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: California

Parent Company if any: SCP Specialty Infusion, LLC

Mailing Address: 15529 College Blvd

City: Lenexa State: KS Zip: 66219

Telephone: 877-342-9352 Fax: 877-542-9352

Contact Person: Jonathan Reinstatler; orxpharmlic@optum.com

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation? N/A
   a) ___________________________ ___________________________
      Name                        Address
   b) ___________________________ ___________________________
      Name                        Address
   c) ___________________________ ___________________________
      Name                        Address
   d) ___________________________ ___________________________
      Name                        Address

2) Provide the number of shares issued by the corporation. N/A

3) What was the price paid per share? N/A

4) What date did the corporation actually receive the cash assets? N/A

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 5:30 pm
   Sunday Closed am pm
   24 Hours on call

Saturday Closed am pm

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. Edward P. Kramm

Responsible Person of BriovaRx Infusion Services 401, 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

Edward P. Kramm

Print Name of Authorized Person

Date

4.5.2019

Page 8
AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Kansas )

Johnson COUNTY ) ss.

Edward P. Kramm, 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 CEO for BriovaRx Infusion Services 401, LLC (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.

Edward P. Kramm, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Name Edward P. Kramm

SUBSCRIBED AND SWORN TO before me, a notary public this 5 day of April, 2019.

Kimberley Williams

NOTARY PUBLIC

My Appointment Expires August 20, 2020
April 17, 2019

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

Re: BriovaRx Infusion Services 401, LLC.
4610 Northgate Blvd. Suite 130
Sacramento, CA 95834

Disciplinary History Letter

To Whom It May Concern:

Corporate Secretary, Karen E. Peterson, paid a fine to the Oregon Board of Pharmacy in 1998 to settle a discipline related to a prescription misfill. The settlement is not available on the Board’s website and she is unable to locate a copy. Ms. Peterson no longer works in this capacity for the Company.

The Kentucky Board of Pharmacy issued a fine against Edward P. Kramm as a pharmacist for failing to complete all required hours of continuing education for 2013. A settlement was signed and Mr. Kramm paid a $500 fine. Mr. Kramm no longer works in this capacity for the company.

Please contact me, at (877) 342-9352 or ORxPharmLic@optum.com if you have any questions or requests for additional information.

Sincerely,

Edward P. Kramm
Chief Executive Officer
### List of Officers and Directors

<table>
<thead>
<tr>
<th>Individual</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edward Paul Kramm</td>
<td>Director, CEO</td>
</tr>
<tr>
<td>Robert Worth Oberrender</td>
<td>Treasurer</td>
</tr>
<tr>
<td>Karen Elizabeth Peterson</td>
<td>Secretary</td>
</tr>
<tr>
<td>Heather Anastasia Lang Jacobsen</td>
<td>Assistant Secretary</td>
</tr>
<tr>
<td>David John Oberg</td>
<td>Assistant Secretary</td>
</tr>
<tr>
<td>David John Maurer</td>
<td>Vice President</td>
</tr>
<tr>
<td>Michael Gerard Zeglinski</td>
<td>Vice President</td>
</tr>
<tr>
<td>Edward Andrew Lagerstrom</td>
<td>Director</td>
</tr>
<tr>
<td>Jeffrey David Grosklags</td>
<td>Director</td>
</tr>
</tbody>
</table>
I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED ARE TRUE AND CORRECT COPIES OF ALL DOCUMENTS ON FILE OF "SCP SPECIALTY INFUSION, LLC" AS RECEIVED AND FILED IN THIS OFFICE.

THE FOLLOWING DOCUMENTS HAVE BEEN CERTIFIED:

CERTIFICATE OF FORMATION, FILED THE FIFTEENTH DAY OF JANUARY, A.D. 2010, AT 2:24 O'CLOCK P.M.

AND I DO HEREBY FURTHER CERTIFY THAT THE AFORESAID CERTIFICATES ARE THE ONLY CERTIFICATES ON RECORD OF THE AFORESAID LIMITED LIABILITY COMPANY, "SCP SPECIALTY INFUSION, LLC".

4777745 8100H

100675756

You may verify this certificate online at corp.delaware.gov/authver.shtml

Jeffrey W. Bullock, Secretary of State
AUTHENTICATION: 8066905
DATE: 06-21-10
CERTIFICATE OF FORMATION
OF
SCP SPECIALTY INFUSION, LLC

This Certificate of Formation of SCP Specialty Infusion, LLC (the "Company"),
is executed by the undersigned for the purpose of forming a limited liability company
pursuant to the Delaware Limited Liability Company Act.

1. The name of the Company is SCP Specialty Infusion, LLC.

2. The address of the registered office of the Company in Delaware is 1209
Orange Street, Wilmington Delaware 19801, New Castle County. The name of the Company’s registered agent at that address is The Corporation
Trust Company.

3. The Company shall have perpetual existence.

IN WITNESS WHEREOF, the undersigned, an authorized person of the
Company, has caused this Certificate of Formation to be duly executed as of the 15th day

Michael J. Welsberg, Organizer
CERTIFICATE OF REGISTRATION

I, ALEX PADILLA, Secretary of State of the State of California, hereby certify:

That on the 20th day of September, 2017, SCP SPECIALTY INFUSION, LLC, complied with the requirements of California law in effect on that date for the purpose of registering to transact intrastate business in the State of California; and further purports to be a limited liability company organized and existing under the laws of Delaware as SCP SPECIALTY INFUSION, LLC and that as of said date said limited liability company became and now is duly registered and authorized to transact intrastate business in the State of California, subject, however, to any licensing requirements otherwise imposed by the laws of this State.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this day of September 21, 2017.

ALEX PADILLA
Secretary of State
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 02857)
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: MILLER'S OF WYCKOFF
Physical Address: 478 WYCKOFF AV
Mailing Address: ________________________________
City: WYCKOFF State: NJ Zip Code: 07481
Telephone: 201-891-3333 Fax: 201-891-6382
Toll Free Number: 888-891-3334 (Required per NAC 639.708)
E-mail: PROOF6@YOURILIKED.COM Website: MILLER'SPHARMACY.COM
Managing Pharmacist: DAVID M. MILLER License Number (NJ) 28RIO0608520

<table>
<thead>
<tr>
<th>TYPE OF PHARMACY AND SERVICES PROVIDED</th>
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</thead>
<tbody>
<tr>
<td>Yes/No</td>
</tr>
<tr>
<td>☐ ☐ Retail</td>
</tr>
<tr>
<td>☐ ☐ Hospital (# beds ____ )</td>
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<td>☐ ☐ Internet</td>
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</tr>
<tr>
<td>☐ ☐ Other Services: _____________________</td>
</tr>
</tbody>
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All boxes must be checked
For the application to be complete

**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

PHILIP J. KOOUKH IV

Print Name of Authorized Person

Date

11-23-18

Board Use Only

Date Processed: 11-23-18

Amount: $300.00
APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: DELAWARE
Parent Company if any: YOUR LIFE RC, INC.
Mailing Address: 3529 CREST ST
City: ST. AUGUSTINE State: FL Zip: 32082
Telephone: 717-856-3433 Fax: —
Contact Person: PHIL KOUGY

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?
   a) BARUCH HALPOIN 9811 COLLINS AVG, BAL HARBOUR, FL 33154
      Name          Address
   b) PHIL KOUGY 3529 CREST ST, ST. AUGUSTINE, FL 32082
      Name          Address
   c) ————————
      Name          Address
   d) ————————
      Name          Address

2) Provide the number of shares issued by the corporation. 950,000

3) What was the price paid per share? 81 0.001

4) What date did the corporation actually receive the cash assets? 12-20-17

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

List any physician shareholders and percentage of ownership.

Name: N/A %: 0
Name: N/A %: 0

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 8 pm  Saturday 9 am 4 pm
Sunday clo 1:00 am 6:00 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: ————
Must be included with the application for a non publicly traded corporation

Certificate of Corporate Status (also referred to as Certificate of Good Standing). The Certificate is obtained from the Secretary of State’s office in the State where incorporated. The Certificate of Corporate status must be dated within the last 6 months.

List of officers and directors

ATTACHED
STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, PHILIP J. ROUGH
Responsible Person of YOUR LIBERTY, INC. DBA MULLINS OR MYCAR
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

Print Name of Authorized Person  Date

Page 8
AFFIDAVIT for Out-of-State Pharmacy License

STATE OF _______________   )
   ) ss.
   ________________ COUNTY   )

I, ___________ PHIL KEOHOU ___________, 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 CEO/PRESIDENT for MILLER'S MYCOTHERAPY (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, ___________ PHIL KEOHOU ___________, 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 4th day of DECEMBER 2018.

RENATA M. WEISS
NOTARY PUBLIC
NEVADA STATE BOARD OF PHARMACY

LICENSEE MAILING ADDRESS FOR WINDOW ENVELOPE

THIS STUB IS YOUR RECEIPT

Date: 11/04/2016
Amount: 500.00
License #: PH02851

MILLERS OF WYCKOFF
678 WYCKOFF AVE
WYCKOFF, NJ 07481

LICENSE

NEVADA
BOARD OF
PHARMACY

Expires: 10/31/2018
MILLERS OF WYCKOFF
678 WYCKOFF AVE
WYCKOFF, NJ 07481

LICENSE #
PH02851
Active

IDENTIFICATION ONLY
DOES NOT MEET POSTING REQUIREMENTS

STATE OF NEVADA
STATE BOARD OF PHARMACY

PHARMACY

License Type: PHARMACY
License #: PH02851
DEA #: BM4899615

Expires: 10/31/2018
STATUS: Active

MILLERS OF WYCKOFF
678 WYCKOFF AVE
WYCKOFF, NJ 07481

NONTRANSFERABLE
POST THIS LICENSE PROMINENTLY IN A CONSPICUOUS PLACE
State Of New Jersey
New Jersey Office of the Attorney General
Division of Consumer Affairs

THIS IS TO CERTIFY THAT THE
Board of Pharmacy

HAS LICENSED

MILLERS OF WYCKOFF INC
DAVID M MILLER
678 WYCKOFF AVE
WYCKOFF NJ 07481-1430

FOR PRACTICE IN NEW JERSEY AS A(N): Pharmacy

09/01/2019 TO 09/30/2019
VALID

Signature of Licensee/Registrant/Certificate Holder

28RS00529600
LICENSE REGISTRATION/CERTIFICATION #

ACTING DIRECTOR
STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF REVENUE AND ENTERPRISE SERVICES
SHORT FORM STANDING

MILLERS OF WYCKOFF, INC.
6085010000

I, the Treasurer of the State of New Jersey, do hereby certify that the above-named New Jersey Domestic For-Profit Corporation was registered by this office on January 02, 1957.

As of the date of this certificate, said business continues as an active business in good standing in the State of New Jersey, and its Annual Reports are current.

I further certify that the registered agent and office are:

DAVID MILLER
678 WYCKOFF AVE
WYCKOFF, NJ 07481

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my Official Seal at Trenton, this 13th day of September, 2018

[Signature]

Elizabeth Maher Muoio
State Treasurer

Certificate Number: 6091219667

Verify this certificate online at
https://www1.state.nj.us/TYTR_StandingCert/JSP/Verify_Cert.jsp
I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF INCORPORATION OF "YOURLIFERX, INC.", FILED IN THIS OFFICE ON THE TWENTIETH DAY OF DECEMBER, A.D. 2017, AT 12:40 O'CLOCK P.M.

A FILED COPY OF THIS CERTIFICATE HAS BEEN FORWARD TO THE NEW CASTLE COUNTY RECORDER OF DEEDS.

[Signature]

Jeffrey W. Bullock, Secretary of State

6671413 8100
SR# 20177685999
Authentication: 203800773
Date: 12-20-17
You may verify this certificate online at corp.delaware.gov/authver.shtml
August 30, 2018

David Miller, RPIC
Millers of Wyckoff Pharmacy
678 Wyckoff Avenue
Wyckoff, New Jersey 07481

Re: Inspection #8-2498-17-160
Date of Inspection: 3/1/17

Dear Mr. Miller:

After affording you an opportunity to discuss the above-referenced matter with the New Jersey State Board of Pharmacy on August 22, 2018, the Board has decided to remove citation N.J.A.C.13:39-11.16(a) and mitigate citation N.J.A.C.13:39-11.24(a)10 to a Warning.

Please complete the attached Certification form and submit $1,000.00 for fines incurred to the Board within 15 days receipt of this letter.

NEW JERSEY STATE BOARD OF PHARMACY

By: Anthony RubinoCio, RPh
Executive Director

AR/th
(8/17)
CERTIFICATION

I, [Name], hereby acknowledge that I have read and reviewed the Board's letter dated August 30, 2018 regarding allegations of violations of the Board's enabling act and/or regulations.

Please Check One:

[ ] I acknowledge the conduct which has been charged and agree to:

Cease and desist from engaging in the conduct alleged and pay a penalty in the amount of $1,000.00 (to be paid upon signing of this Certification).

I am also aware that the action taken against me by the Board herein is a matter of public record, and that the Board's letter and this Certification are public documents.

(Signature)

Dated: 9/4/18

David Miller
(Print Name)

Ref: David Miller, RPIC
Millers of Wyckoff Pharmacy
678 Wyckoff Avenue
Wyckoff, NJ 07481
(28RS00529600)
Inspection #8-2498-17-160

AR/rh
(8/17)
ATTACHMENT A

Millers of Wyckoff Pharmacy – 678 Wyckoff Avenue, Wyckoff, New Jersey 07481
Pharmacist-In-Charge: David Miller
Bureau File #8-2498-17-160, Period: 3/1/17
Reference: Board of Pharmacy inspection conducted per N.J.S.A.45:1-18 and N.J.S.A.45:14-48(a)11&12, and a memorandum, dated February 6, 2017 from Anthony Rubinaccio, Executive Director, Board of Pharmacy, to Edward Tumminello, Chief, Enforcement Bureau, requesting an inspection for the subject pharmacy in connection with an application for a Remodeling.

<table>
<thead>
<tr>
<th>CITE</th>
<th>DESCRIPTION</th>
<th>FINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N.J.A.C.13:39-11.24(a)10</td>
<td>When test result indicated that the cleanroom did not meet the standards established, the pharmacy failed to immediately cease using the cleanroom that was out of compliance until such time that the cleanroom met the requisite standards.</td>
<td>Warning</td>
</tr>
<tr>
<td>N.J.A.C.13:39-11A.9(g)</td>
<td>During the compounding of hormonal products, the pharmacy failed to adhere to standards establish by the Occupational Safety and Health Administration (OSHA): Specifically, most commonly compounded non-sterile preparation are hormonal related products, in the dosage forms of capsules, creams and ointments. Hazardous Active Pharmaceutical Ingredients (API), such as Progesterone and Testosterone, as well as batch prepared hormonal products, were observed to be stored in the active inventory along with non-hazardous API’s.</td>
<td>$1,000.00</td>
</tr>
</tbody>
</table>

TOTAL: $1,000.00
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: 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>
</tr>
</thead>
<tbody>
<tr>
<td>Yes/No</td>
</tr>
<tr>
<td>☐ Retail</td>
</tr>
<tr>
<td>☑ Hospital (# beds ___)</td>
</tr>
<tr>
<td>☐ Internet</td>
</tr>
<tr>
<td>☐ Nuclear</td>
</tr>
<tr>
<td>☐ Ambulatory Surgery Center</td>
</tr>
<tr>
<td>☑ Community</td>
</tr>
<tr>
<td>☐ Other: ________________</td>
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</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)? ☒

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? ☒

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? ☒

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? ☒

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)? ☒

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 Luckaro
Print Name of Authorized Person

10/23/18
Date

Page 2

Board Use Only   Date Processed:          Amount: $000.00
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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
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</tbody>
</table>

List any physician shareholders and percentage of ownership:

<table>
<thead>
<tr>
<th>Name</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
</tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Hours of Operation for the pharmacy:

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

10/25/18
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. 1525

City: Hoffman Estates State: IL Zip: 60169

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

10/23/18

Date
AFFIDAVIT for Out-of-State Pharmacy License

STATE OF ILLINOIS  )
   KANE COUNTY  ) ss.

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.

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

AILEEN M WARREN
NOTARY PUBLIC
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 Estates, 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
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: Westmoreland Pharmacy, Inc.

Physical Address: 1945 State St. STE 100

Mailing Address: 1945 State St. STE 100

City: New Albany State: IN Zip Code: 47150

Telephone: 812-944-6500 Fax: 812-944-6900

Toll Free Number: 1-866-944-6505 (Required per NAC 639.708)

E-mail: info@westmorelandpharmacy.com Website: www.westmorelandpharmacy.com

Managing Pharmacist: Anthony Westmoreland License Number: 26017456A

<table>
<thead>
<tr>
<th>TYPE OF PHARMACY AND SERVICES PROVIDED</th>
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</thead>
<tbody>
<tr>
<td>Yes/No</td>
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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>
</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

Anthony Westmoreland 03/28/2019
Print Name of Authorized Person Date

Board Use Only Date Processed: Amount: $0.00
APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: Indiana

Parent Company if any: ________________________________

Mailing Address: 1945 State St. STE 100

City: New Albany State: IN Zip: 47150

Telephone: 812-944-6500 Fax: 812-944-6900

Contact Person: ________________________________

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?
   a) Anthony Westmoreland 12307 Hummingbird Way Sellersburg, IN 47172
      Name ________________________________ Address ________________________________
   b) ________________________________ ________________________________
   c) ________________________________ ________________________________
   d) ________________________________ ________________________________

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

3) What was the price paid per share? $1

4) What date did the corporation actually receive the cash assets? 08/26/2005

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: ________________________________ %: ________________________________

Hours of Operation for the pharmacy:

Monday thru Friday 8:30 am 7:00 pm  
Saturday 8:30 am 2:00 pm  
Sunday n/a am n/a 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: ________________________________
STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, ________________________________

Responsible Person of ________________________________

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

Anthony Westmoreland
Print Name of Authorized Person

03/28/2019
Date
AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Indiana )
Floyd COUNTY ) ss.

1. Anthony Westmoreland, 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 owner/president for Westmoreland Pharmacy, 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, Anthony Westmoreland, 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 28 day of March, 2020.

NOTARY PUBLIC

[Affidavit Signature]
Your order has been submitted and all fees have been applied to your credit card. If you ordered a card, please allow 5 - 10 business days to receive your order in the mail.

If you selected Free Certificate Printout click Print Receipt at the bottom of the page. This page serves as your certificate and can be used to satisfy any legal posting requirements.

Official License Record

State of Indiana
Official License Record

Full Name: Anthony L Westmoreland
License Number: 26017456A
License Type: Pharmacist
License Status: Active
Issue Date: 10/23/1991
Expiration Date 6/30/2020

Order Information
Date Submitted: 1 June 2018
Applicant Name: Anthony L Westmoreland
License Number: 26017456A
Agency: HPB
Process: Duplicate License process

Payment Information
Authorization Code:
Received Date:
Transaction #:
Credit Card Number:
Fee Amount: $0.00
Service Fee: $2.50
Instant Fee: $0.00
Total Fee: $0.00
List of Officers and Directors:

Anthony Westmoreland, Owner/President
Westmoreland Pharmacy, Inc. Stock Register:

On August 26, 2005 100 shares of Westmoreland Pharmacy stock were created and sold to Anthony Westmoreland for one dollar per share.
DATE: 09-04-2014

TO: Consumer Protection Division, Attorney General’s Office

FROM: Deborah Frye, Compliance, IPLA

SUBJECT: Westmoreland Pharmacy 60005924A 2125 State St. New Albany, IN 47150

The Assistant Director of the Indiana Board of Pharmacy by a pharmacist regarding the compounding Domperidone for human use. The pharmacist was presented with a prescription for oral Domperidone by a patient, he informed them that the product was not available in the US. The patient said that she had been getting it in the hospital and it was compounded by Westmoreland Pharmacy in New Albany. The other question posed by the pharmacist was whether a pharmacy could compound a product and sell it to another pharmacy to be dispensed. Compounded prescriptions are written for a specific patient by a physician and dispensed directly to that patient. The FDA considers this a product that should not be compounded for use in the United States. We would like this information brought before the Indiana Board of Pharmacy for their consideration.
Westmoreland Pharmacy
2125 State Street
New Albany, IN 47150

Re: File No. 14-CP-60146 Indiana Professional Licensing Agency vs. Westmoreland Pharmacy

Dear Westmoreland Pharmacy:

Enclosed is a copy of a complaint received by the Licensing Enforcement & Homeowner Protection Unit ("Unit"). Indiana law requires the Unit to investigate complaints against licensed professionals and deceptive acts in connection with real estate transactions. The Unit also investigates complaints concerning the unlicensed practice of professions regulated under Title 25.

You may provide a written response within twenty (20) days of the date of this letter. You may submit your response via e-mail or fax.

Please include the following information in your response:

1. The file number shown above;
2. My name, Audrea Racine
3. Your explanation of what happened;

If your written response is not received within the above-mentioned time period, the investigation will continue without the benefit of your input.

You will be advised of the final disposition of the investigation once it is completed. If you have any further questions, do not hesitate to contact me.

Sincerely,

Audrea Racine
Case Analyst
audrea.racine@atg.in.gov
Office of the Indiana Attorney General

Indianapolis, IN 46204

Re: File No. 14-CP-60146

October 6, 2014

Dear Ms. Racine,

I am writing in response to the attached complaint your office sent to me on September 17, 2014 regarding Domperidone.

On or around the beginning of this year, 2014, our pharmacy was contacted by the local hospital – Floyd Memorial Hospital and Health Services in New Albany, IN. The pharmacy stated that they had been getting Domperidone oral capsules compounded for in-patient use by a local compounding pharmacy in New Albany. But apparently that pharmacy could no longer supply it. The hospital uses Domperidone for particularly resistant cases of gastroparesis as prescribed by attending Gastroenterologists. The Hospital asked if we could begin supplying the Domperidone to them. Our pharmacy responded that we would have to try and source the chemical first and let them know. We contacted CBS Chemical in Phoenix, AZ and they agreed to provide the product to us.

Once we received the chemical, our pharmacy began supplying Domperidone 10mg capsules to the hospital for in-patient use. Also, we began to see prescriptions for patients once they left the hospital. We filled these prescriptions for home use.

Your letter came with great concern. We immediately researched and understood the validity of the complaint. The fact that this drug requires an IND in the U.S. in order to be dispensed became apparent to us. Our pharmacy takes great pride in complying with rules and regulations. We have previously been accredited by the Pharmacy Compounding Accreditation Board. We realized the significance of our actions. Thus, immediately we did the following:

1. Ceased and desisted in dispensing further Rx’s for Domperidone in any form.
2. Contacted patients and Providers to notify them we would no longer be able to provide Domperidone.
3. Quarantined all Domperidone chemical and readied for reverse distribution.
4. Updated our pharmacy SOP to include a section “Determining drugs that are legal to compound”.
5. Advising all staff of the events and making it mandatory to sign off on the new SOP section.

As I stated earlier, we take these matters seriously. We hope our actions, in response, have been a good faith effort to correct our deficiency. Please let us know what additional steps, if any, we need to take to resolve this situation.

Sincerely,

[Signature]

Anthony L. Westmoreland, RPh
Westmoreland Pharmacy Inc.
BEFORE THE INDIANA
BOARD OF PHARMACY
CAUSE NUMBER: 2015 IBP 0053

IN THE MATTER OF THE INDIANA PHARMACY LICENSE OF
WESTMORELAND PHARMACY, INC. LICENSE NO.: 60005924A

HEARING NOTICE

Comes now the INDIANA BOARD OF PHARMACY ("Board") pursuant to Ind.
Code § 4-21.5-3-20 and issues the following Hearing Notice:

1. This notice is being provided to Westmoreland Pharmacy, Inc. ("Respondent"), 2125
   State Street, New Albany, Indiana 47150.

2. This notice is being provided to counsel for State of Indiana, N. Renee Gallagher, Deputy
   Attorney General, Office of the Attorney General, Indiana Government Center South, 5th
   floor, Indianapolis, Indiana 46204, telephone number (317) 234-7114.

3. The official cause number of this action is: 2015 IBP 0053.

4. This hearing is to address the issues raised in the Complaint, which is attached hereto as
   Exhibit A.

5. A hearing regarding this matter will be held on February 8, 2016, at 1:30 p.m., Eastern
   Standard Time, in the Indiana Government Center South, Room W064, located at 402
   West Washington Street, Indianapolis, Indiana 46204.

6. The Board is empowered to hold this disciplinary hearing pursuant to the authority of
   Ind. Code § 25-1-9 and Ind. Code § 4-21.5 et seq.

7. The Board will be presiding as administrative law judge in this matter. Theodore
   Cotterill, Director of the Board, may be contacted to obtain information concerning
CERTIFICATE OF SERVICE

I certify that a copy of the “Hearing Notice” has been duly served upon:

Westmoreland Pharmacy, Inc.
2125 State Street
New Albany, Indiana 47150
Service by U.S. Mail

N. Renee Gallagher
Deputy Attorney General
Office of the Attorney General
Indiana Government Center South
402 West Washington Street, 5th Floor
Indianapolis, Indiana 46204
Service by E-mail

January 25, 2016
Date

Theodore C. Cotterill, Director
Indiana Board of Pharmacy

Indiana Board of Pharmacy
Indiana Government Center South
402 West Washington St., Room W072
Indianapolis, Indiana 46204
Phone: 317-234-2067
Fax: 317-233-4236
Email: pla4@pla.in.gov

Explanation of Service Methods
Personal Services: by delivering a true copy of the aforesaid document(s) personally.
Service by U.S. Mail: by serving a true copy of the aforesaid document(s) by First Class U.S. Mail, postage prepaid.
Service by Email: by sending a true copy of the aforesaid document(s) to the individual’s electronic mail address.
BEFORE THE INDIANA BOARD OF PHARMACY
CAUSE NO: 2015 IBP 0053

IN THE MATTER OF THE INDIANA
PHARMACY LICENSE OF

WESTMORELAND PHARMACY, INC.

LICENSE NUMBER 60005924A (ACTIVE)
(CLOSED DOOR III)

FILED
OCT 14 2015
Indiana Professional Licensing Agency

ADMINISTRATIVE COMPLAINT

This complaint is brought against the pharmacy license of Westmoreland Pharmacy, Inc. ("Respondent"), by the Office of the Attorney General, by counsel, Deputy Attorney General Stephanie E. Sluss, on behalf of the State of Indiana ("Petitioner") and pursuant to Ind. Code § 25-1-7-7, Ind. Code § 25-1-5-3, Ind. Code ch. 25-26, the Administrative Orders and Procedures Act, Ind. Code art. 4-21.5 and Ind. Code ch. 25-1-9 and in support alleges and states:

FACTS

1. Respondent is a licensed closed door pharmacy in the State of Indiana having been issued license number 60005924A on or about December 20, 2005. Said license is currently active.

2. Respondent’s address of record with the Indiana Professional Licensing Agency is 2125 State Street, New Albany, IN 47150.

3. On or around the beginning of 2014, Respondent began compounding drug products containing Domperidone.

4. Domperidone is a drug used to increase milk production in breastfeeding women, which is not an approved use, and to treat certain gastric disorders.
5. Domperidone is not approved for use in any country for breastfeeding women and only in the United States for use in treating certain gastric disorders under special conditions which are outlined by the FDA.

6. Domperidone was removed from the market by the Food and Drug Administration ("FDA") in 1998 due to serious adverse effects, including irregular heartbeat, stopping of the heart, or sudden death. These dangers could convey to nursing babies of breastfeeding women.

7. In June 2004, the FDA issued a “Talk Paper” warning breastfeeding women not to use Domperidone and issued warning letters to pharmacies that compounded products containing Domperidone and firms that supplied Domperidone for use in compounding.

8. Since June 2004, the FDA has issued several warning letters to pharmacies and firms regarding compounding, supplying or distributing Domperidone.

9. The FDA also issued an “Import Alert” alerting FDA field personnel to watch for imports of Domperidone and to detain and refuse admission as appropriate.

10. In March 2012, the FDA issued another “Import Alert” advising that Domperidone was being imported as a bulk active pharmaceutical ingredient for compounding, and in a finished dosage form. The FDA warned that the importation of Domperidone presents a “public health risk” and violates the FDCA.

11. Domperidone can only be obtained in the United States through the FDA’s Expanded Access to Investigational Drugs Program ("IND"), and then only for patients 12 years of age and older with certain gastric disorders.

12. Prior to prescribing or dispensing Domperidone, a health care practitioner must submit an application to the FDA to become a Sponsor-Investigator as part of the IND and the
IND must be in effect prior to the importation, interstate shipment, and administration of Domperidone.

13. To obtain Domperidone, the FDA has authorized only specific suppliers to provide the drug.

14. A health care practitioner who is a Sponsor-Investigator can obtain Domperidone for their patients through either direct import to their office for dispensing from one of the approved manufacturers, or by direct shipment to the patient by the approved pharmacy supplier.

15. Respondent received Domperidone from CBS Chemical in Phoenix, AZ, an unauthorized distributor of Domperidone.

16. Respondent used this bulk product to compound Domperidone for patients with certain gastric disorders and without INDs in place.

17. Respondent supplied a local hospital with Domperidone drug products and also filled prescriptions for individuals to use the drug at home.

18. Respondent indicated that it has ceased compounding Domperidone after receiving a consumer complaint in September of 2014 and conducting independent research on the drug.

**COUNT I**

19. Paragraphs 1 (one) through 18 (eighteen) are incorporated by reference herein.

20. Respondent violated Ind. Code § 25-1-9-4(a)(4)(A) in that Respondent has continued to practice although it has become unfit to practice due to professional incompetence as evidenced by, which includes but is not limited to, Respondent compounding Domperidone and supplying it to a hospital and individuals.
COUNT II

21. Paragraphs 1 (one) through 18 (eighteen) are incorporated by reference herein.

22. Respondent violated Ind. Code § 25-1-9-4(a)(4)(B) in that Respondent has continued to practice although it has become unfit to practice due to failure to keep abreast of current professional theory or practice as evidenced by, which includes but is not limited to, Respondent compounding Domperidone and supplying it to a hospital and individuals.

WHEREFORE, Petitioner demands an order against the Respondent that:

1. Imposes the appropriate disciplinary sanction;

2. Directs Respondent to immediately pay all of the cost incurred in the prosecution of this case;

3. Directs Respondent to pay a fee of Five Dollars ($5.00) to be deposited into the Health Records and Personal Identifying Information Protection Trust Fund pursuant to Ind. Code § 4-6-14-10(b); and

4. Provide any other relief the Board deems just and proper within the premises.

Respectfully submitted,

Gregory F. Zoeller
Attorney General of Indiana
Atty. No. 1958-98

By:
Stephanie E. Sluss
Deputy Attorney General
Attorney No. 26920-49
January 19, 2017

CERTIFIED MAIL

WESTMORELAND PHARMACY & COMPOUN
ATTN: ANTHONY WESTMORELAND
1945 STATE ST.
NEW ALBANY, IN 47150

RE: CI 2016 71933
WESTMORELAND PHARMACY & COMPOUNDING
Unlicensed

After thorough and careful consideration of the explanation and information you provided at the office conference, the committee determined that the information presented had been previously considered and was not new information. The committee decided to affirm the above-referenced Citation and Fine, CI 2016 71933 as originally issued.

This decision is the final administrative order regarding the Citation. Since you did not timely request a hearing to contest the Citation pursuant to California Code of Regulations, title 16, section 1775.4, subdivision (a), the administrative appeals process has concluded.

Failure to pay any imposed fine(s) within 30 days of the date of this letter may result in disciplinary action being taken. The timely payment of the imposed fine(s) shall not constitute an admission of the violation(s) charged in the Citation.

If any fine(s) are not timely paid, then the full amount of the unpaid fine(s) shall be added to the fee for the renewal of your license. Your license shall not then be renewed without full payment of the renewal fee and the assessed fine(s).

Please contact Associate Enforcement Analyst Jennifer Sevilla at (916) 574-7925, if you have any questions.

Sincerely

[Signature]

Virginia Herold
Executive Officer
Board of Pharmacy
DECLARATION OF SERVICE BY CERTIFIED MAIL

RE: WESTMORELAND PHARMACY & COMPOUNDING Unlicensed
Citation CI 2016 71933

I declare:

I am employed in the County of Sacramento, California. I am over 18 years of age and not a party to the within entitled cause. My business address is 1625 North Market Boulevard, Suite N219, Sacramento, California 95834-1924.

On January 19, 2017, I served the attached:
Decision letter from office conference.

in said cause, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid by Certified Mail, in the United States mail at Sacramento, California, addresses as follows:

NAME
WESTMORELAND PHARMACY & COMPOUNDING
ATTN: ANTHONY WESTMORELAND
1945 STATE ST.
NEW ALBANY, IN 47150

CERTIFIED MAIL NO
7016 1370 0000 5640 5975

I declare under penalty of perjury that the forgoing is true and correct.

Executed on January 19, 2017, at Sacramento, California.

[Signature]
DECLARANT

Jennifer Sevilla
Associate Enforcement Analyst
BEFORE THE INDIANA BOARD OF PHARMACY  
CAUSE NO: 2015 IBP 0053  

IN THE MATTER OF THE INDIANA PHARMACY LICENSE OF  
WESTMORELAND PHARMACY, INC. LICENSE NUMBER 60005924A  

FINAL ORDER ACCEPTING PROPOSED SETTLEMENT AGREEMENT  

The State of Indiana ("Petitioner"), by Amelia A. Hilliker, and Williams Bros. Health Care Pharmacy of Bloomington, Inc. ("Respondent"), signed a "Settlement Agreement" ("Agreement"), filed on April 4, 2017, which purports to resolve all issues involved in the action by the Petitioner and the Indiana Board of Pharmacy ("Board") regarding the Respondent’s license, and which Agreement has been submitted to the Board for approval.  

The Board after reviewing the Agreement at the April 10, 2017, meeting held in Room W064 of the Indiana Government Center South, 402 West Washington Street, Indianapolis, Indiana 46204, now finds it has been entered into fairly and without fraud, duress, or undue influence, and is fair and equitable between the parties. The Board hereby incorporates the Agreement which is attached hereto and incorporated herein as Exhibit A, into this Final Order.  

WHEREFORE, the Board hereby accepts and approves the Findings of Facts, Conclusions of Law, and Agreed Disposition presented by the parties and issues this Final Order, by a vote of 6-0:  

1. Respondent’s Indiana pharmacy license shall be issued LETTER OF REPRIMAND, which will be included as a permanent part of Respondent’s file located at the Indiana Professional Licensing Agency.
2. Respondent will ensure compounding staff undergo ten (10) hours of continuing education in the areas of FDA Regulations within one (1) year of the date of the Board's Final Order accepting this Agreement and provide proof of completion to the Board.

3. Within thirty (30) days of the date of this Order, Respondent shall, pursuant to I.C. § 4-6-14-10(b), pay a fee of Five Dollars ($5.00) to be deposited into the Health Records and Personal Identifying Information Protection Trust Fund. This fee shall be paid by check or money order made payable to the State of Indiana and submitted to the following address:

   Indiana Office of the Attorney General  
   Attn: Teresa Henson  
   302 W. Washington Street, 5th Floor  
   Indianapolis, IN 46204

4. A violation of this Final Order, any non-compliance with the statutes or regulations regarding the practice of pharmacy may result in an Order to Show Cause as may be issued by the Board, or a new cause of action pursuant to Ind. Code § 25-1-9-4, and or all of which could lead to additional sanctions.

   SO ORDERED, this _____ day of February, 2017.

   INDIANA BOARD OF PHARMACY

   ____________________________  
   Steve Anderson, R. Ph, Vice President  
   Indiana Board of Pharmacy
CERTIFICATE OF SERVICE

I certify that a copy of the “Final Order Accepting Proposed Settlement Agreement” has been duly served upon:

Westmoreland Pharmacy, Inc.
c/o Anthony Westmoreland
2125 State Street
New Albany, IN 47150

Service by US Mail

Amelia A. Hilliker
Deputy Attorney General
302 West Washington Street, 5th Floor
Indianapolis, IN 46204
Amelia.Hilliker@atg.in.gov
Service by E-Mail

Date

Litigation Specialist

Telephone: 317-234-2067
Email: pla4@pla.in.gov

Explanation of Service Methods
Personal Service: by delivering a true copy of the aforesaid document(s) personally.
Service by U.S. Mail: by serving a true copy of the aforesaid document(s) by First Class U.S. Mail, postage prepaid.
Service by Email: by sending a true copy of the aforesaid document(s) to the individual’s electronic mail address.
January 9, 2018

Dear Board of Pharmacy,

Pursuant to the attached Letter of Reprimand that our pharmacy received, please find the REQUIRED 10 HOURS OF CONTINUING EDUCATION PERFORMED BY COMPOUNDING STAFF.

We have 3 compounding staff members that performed the CE:

Anthony Westmoreland PIC
Tahnee Miller RPh Compounding Pharmacist
Randy Bryan Smith CPhT Compounding Technician

If there are any further questions, please feel free to contact me directly at 502-298-9085.

Sincerely,

Anthony Westmoreland RPh
Owner, Westmoreland Pharmacy
**CPE Monitor Activity Transcript**

**Participant Name:** Tahnee Lynne Miller — RPh Compounding Pharmacist

**NABP e-Profile ID:** 278939

**CPE Activity Date Range:** 11/01/2017 - 01/08/2018

**Total CPE Hours Earned:** 37.0

Recorded CPE activity for the period of 11/01/2017 to 01/08/2018. Please allow 60 days for the CPE Provider to process your CPE and submit it through the CPE Monitor System. If it has been more than 60 days since you submitted the necessary information for CPE credit, please contact the CPE Provider.

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<th>Activity Date</th>
<th>ACPE UAN</th>
<th>Title</th>
<th>Provider</th>
<th>Format</th>
<th>Topic Designators</th>
<th>Contact Hours (CEU)</th>
<th>Live Hours</th>
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<td>0422-0000-17-236-H07-P</td>
<td>Compounding: Managing Sterile Compounding</td>
<td>Therapeutic Research Center</td>
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<td>Compounding: Understanding Requirements for Sterile Compounding</td>
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<td>Compounding: Complex Nonsterile Compounding: Topical Dosage Forms</td>
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<td>Compounding: Sterile Compounding and USP Chapter &lt;97&gt;</td>
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<td>0422-0000-17-710-H01-P</td>
<td>Emerging Developments in Drug Therapy and Implementation into Patient Care: October 2017</td>
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<td>Emerging Developments in Drug Therapy and Implementation into Patient Care: February 2017</td>
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</table>

This statement contains information provided to NABP from the Accreditation Council for Pharmacy Education (ACPE). The CPE provider is responsible for the accuracy of the CPE course data on the statement; however, NABP affirms that the participation information has been matched to the corresponding e-Profile data within its systems. Requests for changes to CPE course data must be directed to the ACPE-accredited provider that offered the course. CPE documentation requirements are determined by each Board of Pharmacy; please check with your licensing board about these requirements. CPE information has been made available to licensees’ respective board(s) of pharmacy for use at the boards’ discretion.
CPE Monitor Activity Transcript

Participant Name: Randy Bryan Smith  —  CPHT COMPOUNDING LAB
NABP e-Profile ID: 487505
CPE Activity Date Range: 10/03/2013 - 12/29/2017
Total CPE Hours Earned: 23.5

Recorded CPE activity for the period of 10/03/2013 to 12/29/2017. Please allow 60 days for the CPE Provider to process your CPE and submit it through the CPE Monitor System. If it has been more than 60 days since you submitted the necessary information for CPE credit, please contact the CPE Provider.

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<tr>
<th>Activity Date</th>
<th>ACPE UAN</th>
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<th>Topic Designators</th>
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<td>0798-0000-16-090-H04-T</td>
<td>The Compounding Side of Hormone Therapy for Men and Women</td>
<td>PharmCon, Inc.</td>
<td>Home</td>
<td>General Pharmacy Topics</td>
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<td>12/26/2017</td>
<td>0798-0000-15-122-H03-T</td>
<td>Compounded Medicines: New Laws, New Responsibilities, New Questions</td>
<td>PharmCon, Inc.</td>
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<td>Law</td>
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<td>0798-0000-16-137-H04-T</td>
<td>Decoding the Drug Quality and Security Act Pertinent to Sterile and Non-Sterile Compounding</td>
<td>PharmCon, Inc.</td>
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<td>0401-0000-16-504-H03-T</td>
<td>DSN Quick Credit: Applying law to pharmaceutical compounding</td>
<td>Drug Store News</td>
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<td>USP 800 Compliance</td>
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<td>0280-0000-16-082-H03-P</td>
<td>Sterile Compounding Update: Laws, Regulations &amp; Standards</td>
<td>American Health Resources</td>
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<td>0201-0000-11-039-L01-T</td>
<td>Aseptic Technique Compounding</td>
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Print Date: 01/09/2018  Page: 1
**CPE Monitor Activity Transcript**

Participant Name: Anthony Lee Westmoreland

NABP e-Profile ID: 390818

CPE Activity Date Range: 12/01/2017 - 01/01/2018

Total CPE Hours Earned: 15.0

Recorded CPE activity for the period of 12/01/2017 to 01/01/2018. Please allow 60 days for the CPE Provider to process your CPE and submit it through the CPE Monitor System. If it has been more than 60 days since you submitted the necessary information for CPE credit, please contact the CPE Provider.

<table>
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<tr>
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<td>Controlled Substances: Preventing Diversion and Promoting Patient Safety with Opioids</td>
<td>Therapeutic Research Center</td>
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<td>0422-0000-16-215-H01-P</td>
<td>The Balancing Act with Controlled Substances: Ensuring Access for Patients with Valid Prescriptions</td>
<td>Therapeutic Research Center</td>
<td>Home</td>
<td>Drug Therapy Related</td>
<td>2.0 (0.2)</td>
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<td>12/25/2017</td>
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<td>Compounding: Understanding Requirements for Sterile Compounding</td>
<td>Therapeutic Research Center</td>
<td>Home</td>
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This statement contains information provided to NABP from the Accreditation Council for Pharmacy Education (ACPE). The CPE provider is responsible for the accuracy of the CPE course data on the statement; however, NABP affirms that the participation information has been matched to the corresponding e-Profile data within its systems. Requests for changes to CPE course data must be directed to the ACPE-accredited provider that offered the course.

CPE documentation requirements are determined by each Board of Pharmacy; please check with your licensing board about these requirements. CPE information has been made available to licensees' respective board(s) of pharmacy for use at the boards' discretion.

Print Date: 01/08/2018
BEFORE THE INDIANA BOARD OF PHARMACY
CAUSE NO: 2015 IBP 0053

IN THE MATTER OF THE INDIANA
PHARMACY LICENSE OF

WESTMORELAND PHARMACY, INC.
LICENSE NUMBER 60005924A

PROPOSED SETTLEMENT AGREEMENT

The State of Indiana ("Petitioner"), by Amelia A. Hilliker, Deputy Attorney General, and Westmoreland Pharmacy, Inc. ("Respondent"), hereby execute this Settlement Agreement ("Agreement") to a disposition of the Administrative Complaint filed in this cause with the Indiana Board of Pharmacy ("Board"). This Agreement is subject to the review of the Board pursuant to Ind. Code § 25-1-9 et seq. and the Administrative Orders and Procedures Act, Ind. Code § 4-21.5-3 et seq.

STIPULATED FACTS

1. Respondent is a licensed closed door pharmacy in the State of Indiana having been issued license number 60005924A on or about December 20, 2005.

2. Respondent's address of record with the Indiana Professional Licensing Agency is 2125 State Street, New Albany, IN 47150.

3. On or around the beginning of 2014, Respondent began compounding drug products containing Domperidone.

4. Domperidone is approved for use in the United States in treating certain gastric disorders under special conditions which are outlined by the FDA.

5. Domperidone was removed from the market by the Food and Drug Administration ("FDA") in 1998 due to serious adverse effects, including irregular heartbeat, stopping of the heart, or sudden death.

1
6. Domperidone can only be obtained in the United States through the FDA’s Expanded Access to Investigational Drugs Program ("IND"), and then only for patients 12 years of age and older with certain gastric disorders.

7. Prior to prescribing or dispensing Domperidone, a health care practitioner must submit an application to the FDA to become a Sponsor-Investigator as part of the IND and the IND must be in effect prior to the importation, interstate shipment, and administration of Domperidone.

8. To obtain Domperidone, the FDA has authorized only specific suppliers to provide the drug.

9. A health care practitioner who is a Sponsor-Investigator can obtain Domperidone for their patients through either direct import to their office for dispensing from one of the approved manufacturers, or by direct shipment to the patient by the approved pharmacy supplier.

10. Respondent compounded drug products containing Domperidone pursuant to a valid prescription for individual patients who did not have an IND in place.

11. Respondent conducted the activities described in Paragraph 10 above, without knowledge or belief that its actions were in violation of federal or state law. Respondent acted in reliance on materials widely distributed by a national trade association representing compounding pharmacies.


**STIPULATED CONCLUSIONS OF LAW**

The parties further stipulate:


AGREED DISPOSITION

The parties agree to the following disposition:

1. The Board has jurisdiction over Respondent and the subject matter in this disciplinary action.

2. The parties execute this Agreement voluntarily.

3. Both parties voluntarily waive their rights to a public hearing on the Complaint and all other proceedings in this action to which either party may be entitled by law, including judicial review and appeal.

4. Petitioner agrees that the terms of this Agreement will resolve any and all pending claims or allegations relating to disciplinary action against the Respondent’s Indiana pharmacy license.

5. Respondent agrees that they will receive the attached LETTER OF REPRIMAND, which will be included as a permanent part of Respondent’s file located at the Indiana Professional Licensing Agency. (See Letter of Reprimand attached hereto as Exhibit “A”.)

6. Respondent will ensure compounding staff undergo ten (10) hours of continuing education in the areas of FDA Regulations within one (1) year of the date of the Board’s Final Order accepting this Agreement and provide proof of completion to the Board.
7. Within thirty (30) days of the date of the Board's Final Order accepting this Agreement, Respondent shall, pursuant to I.C. § 4-6-14-10 (b), pay a fee of Five Dollars ($5.00) to be deposited into the Health Records and Personal Identifying Information Protection Trust Fund. This fee shall be paid by check or money order made payable to the State of Indiana, and submitted to the following address:

Indiana Office of the Attorney General
Attn: Teresa Henson
302 West Washington Street, 5th Floor
Indianapolis, IN 46204.

8. Respondent has carefully read and examined this Agreement and fully understands its terms and that, subject to a final order issued by the Board, this Agreement is a final disposition of all matters and not subject to further review.

9. Respondent further understands that a violation of the Final Order accepting this Agreement, any non-compliance with the statutes or regulations regarding the practice of pharmacy, or any violation of the Settlement Agreement may result in the State requesting an emergency suspension of the Respondent's license, an Order to Show Cause as may be issued by the Board, or a new cause of action pursuant to I.C. § 25-1-9-4, any or all of which could lead to additional sanctions, up to and including a revocation of Respondent's license.

[Signatures]

Westmoreland Pharmacy, Inc.

Amelia A. Hilliker
Deputy Attorney General

4-3-17
Date

4-1-2017
Date
March 28, 2017

Westmoreland Pharmacy, Inc.
2125 State Street
New Albany, IN 47150

Re: In the matter of the license of Westmoreland Pharmacy, LLC
Before the Indiana Board of Pharmacy

To Whom it May Concern:

This letter of reprimand issued in accordance with the Findings of Fact and Order issued by the Indiana Board of Pharmacy resolving the administrative complaint against your pharmacy license filed by the Office of the Attorney General, Division of Consumer Protection on October 14, 2015.

The purpose of this reprimand is to stress the important responsibility that you have by reason of possession of a pharmacy license in the State of Indiana.

The Settlement Agreement, Findings of Fact, and Final Order are attached and incorporated herein as part of this reprimand.

It is your responsibility to conduct your practice as a pharmacy in accordance with the statutes, regulations, and standards of the profession.

Sincerely,

INDIANA BOARD OF PHARMACY

By: ____________________________
    Steve Anderson, R.Ph., President

EXHIBIT “A”
IN THE MATTER OF THE INDIANA PHARMACY LICENSE OF WESTMORELAND PHARMACY, INC. LICENSE NUMBER 60005924A

BEFORE THE INDIANA BOARD OF PHARMACY CAUSE NO: 2015 IBP 0053

FINAL ORDER ACCEPTING PROPOSED SETTLEMENT AGREEMENT

The State of Indiana ("Petitioner"), by Amelia A. Hilliker, and Westmoreland Pharmacy, Inc. ("Respondent"), signed a "Settlement Agreement" ("Agreement"), filed on April 4, 2017, which purports to resolve all issues involved in the action by the Petitioner and the Indiana Board of Pharmacy ("Board") regarding the Respondent’s license, and which Agreement has been submitted to the Board for approval.

The Board after reviewing the Agreement at the April 10, 2017, meeting held in Room W064 of the Indiana Government Center South, 402 West Washington Street, Indianapolis, Indiana 46204, now finds it has been entered into fairly and without fraud, duress, or undue influence, and is fair and equitable between the parties. The Board hereby incorporates the Agreement which is attached hereto and incorporated herein as Exhibit A, into this Final Order.

WHEREFORE, the Board hereby accepts and approves the Findings of Facts, Conclusions of Law, and Agreed Disposition presented by the parties and issues this Final Order, by a vote of 6-0:

1. Respondent’s Indiana pharmacy license shall be issued LETTER OF REPRIMAND, which will be included as a permanent part of Respondent’s file located at the Indiana Professional Licensing Agency.
2. Respondent will ensure compounding staff undergo ten (10) hours of continuing education in the areas of FDA Regulations within one (1) year of the date of the Board’s Final Order accepting this Agreement and provide proof of completion to the Board.

3. Within thirty (30) days of the date of this Order, Respondent shall, pursuant to I.C. § 4-6-14-10(b), pay a fee of Five Dollars ($5.00) to be deposited into the Health Records and Personal Identifying Information Protection Trust Fund. This fee shall be paid by check or money order made payable to the State of Indiana and submitted to the following address:

   Indiana Office of the Attorney General
   Attn: Teresa Henson
   302 W. Washington Street, 5th Floor
   Indianapolis, IN 46204

4. A violation of this Final Order, any non-compliance with the statutes or regulations regarding the practice of pharmacy may result in an Order to Show Cause as may be issued by the Board, or a new cause of action pursuant to Ind. Code § 25-1-9-4, and or all of which could lead to additional sanctions.

   SO ORDERED, this 16th day of May, 2017.

   INDIANA BOARD OF PHARMACY

   [Signature]
   Steve Anderson, R. Ph, Vice President
   Indiana Board of Pharmacy
CERTIFICATE OF SERVICE

I certify that a copy of the “Final Order Accepting Proposed Settlement Agreement” has been duly served upon:

Westmoreland Pharmacy, Inc.
c/o Anthony Westmoreland
1945 State Street
New Albany, IN 47150
Service by US Mail

Amelia A. Hilliker
Deputy Attorney General
302 West Washington Street, 5th Floor
Indianapolis, IN 46204
Amelia.Hilliker@atg.in.gov
Service by E-Mail

5-10-17
Date

Indiana Board of Pharmacy
Indiana Government Center South
302 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: 317-234-2067
Email: pla4@pla.in.gov

Explanation of Service Methods
Personal Service: by delivering a true copy of the aforesaid document(s) personally.
Service by U.S. Mail: by serving a true copy of the aforesaid document(s) by First Class U.S. Mail, postage prepaid.
Service by Email: by sending a true copy of the aforesaid document(s) to the individual’s electronic mail address.

Donna Moran, Litigation Specialist
May 9, 2017

Westmoreland Pharmacy, Inc.
2125 State Street
New Albany, IN 47150

Re: In the matter of the license of Westmoreland Pharmacy, LLC
Before the Indiana Board of Pharmacy

To Whom it May Concern:

This letter of reprimand issued in accordance with the Findings of Fact and Order issued by the Indiana Board of Pharmacy resolving the administrative complaint against your pharmacy license filed by the Office of the Attorney General, Division of Consumer Protection on October 14, 2015.

The purpose of this reprimand is to stress the important responsibility that you have by reason of possession of a pharmacy license in the State of Indiana.

The Settlement Agreement, Findings of Fact, and Final Order are attached and incorporated herein as part of this reprimand.

It is your responsibility to conduct your practice as a pharmacy in accordance with the statutes, regulations, and standards of the profession.

Sincerely,

INDIANA BOARD OF PHARMACY

By: Maureen Bennett

Steve Anderson, R.Ph., President

EXHIBIT “A”

Page 4 of 4
State of Illinois

Board of Pharmacy

February 6, 2018

RE: No. 2017-01360

This is the written answer to the above-referenced complaint against our pharmacy, Westmoreland Pharmacy at 1945 State St, New Albany IN 47150.

Count 1, Paragraphs 1-9

We admit this allegation.

Count 2, Paragraph 10

We admit this allegation.

Please contact me directly at 502-298-9085 if there are any further questions. Sincerely,

[Signature]

Anthony L. Westmoreland RPh

PIC, Westmoreland Pharmacy

Illinois License 054.016721,320.009596
INDIVIDUAL ACKNOWLEDGMENT

State/Commonwealth of Indiana } ss.
County of Floyd.

On this the 6th day of February, 2018, before me, Laurea Wheatley, the undersigned Notary Public, personally appeared Anthony L. Westmoreland.

☐ personally known to me — OR —
☐ proved to me on the basis of satisfactory evidence
to be the person(s) whose name(s) is/are subscribed to the within instrument, and acknowledged to me that he/she/they executed the same for the purposes therein stated.

WITNESS my hand and official seal.

LAURA WHEATLEY
Notary Public - Seal
State of Indiana
My Commission Expires Aug 9, 2021

Place Notary Seal/Stamp Above

Any Other Required Information
(Printed Name of Notary, Expiration Date, etc.)

INFORMATION IN AREA 3 1-4 REQUIRED IN ARIZONA. OPTIONAL IN OTHER STATES.

Description of Any Attached Document

1 Title or Type of Document: St. of Illinois Board of Pharmacy

2 Document Date: February 6, 2018

3 Number of Pages: 1

4 Signer(s) Other Than Named Above: N/A

© 2012 National Notary Association • NationalNotary.org • 1-800-US NOTARY (1-800-876-8827) Item #25936
STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISION OF PROFESSIONAL REGULATION

DEPARTMENT OF FINANCIAL AND
PROFESSIONAL REGULATION, DIVISION OF
PROFESSIONAL REGULATION

of the State of Illinois, Complainant, No. 2017-01360

v.

WESTMORELAND PHARMACY INC,
License No. 054.016721, 320.009596,

Respondent.

NOTICE OF PRELIMINARY HEARING

TO: WESTMORELAND PHARMACY INC
   ANTHONY WESTMORELAND
   1945 STATE ST
   NEW ALBANY, IN 47150-4919

PLEASE TAKE NOTICE that on March 19th, 2018, at 1:00 p.m., you
are directed to appear before the Administrative Law Judge of the Division of Professional
Regulation of the Department of Financial and Professional Regulation of the State of Illinois,
located at 100 West Randolph Street, Suite 9-300, Chicago Illinois 60601, at which time a hearing
date will be set. You are requested to then and there present any and all routine motions you may
wish to have heard regarding the charges contained in the attached Complaint. Any motions
presented on the above date should be served on the Adjudicative Services Unit of the Department of
Financial and Professional Regulation, Division of Professional Regulation, 100 West Randolph
Street, Suite 9-300, Chicago Illinois 60601 at least three (3) business days in advance of the
scheduled hearing.

Your appearance on the scheduled date and time is mandatory and your failure to so appear
may result in the selection of a hearing date in your absence, unless a continuance has been secured
in advance. Your appearance may be made personally or through counsel.

It is required that you file a written ANSWER UNDER OATH AND UNDER PENALTY
OF PERJURY to the attached Complaint under oath with the Department of Professional Regulation
within (20) days of the date this Notice was mailed. The answer should address each numbered
paragraph of the Complaint. The answer shall be signed under oath and your signature must be
verified by a notary public who affixes the notary seal to the document. For each paragraph, the
Answer should either:

a) admit the allegation in the paragraph
b) deny the allegation in the paragraph, or
c) state under oath that you have insufficient information with which to admit or deny the
   allegation in the paragraph
PLEASE BE ADVISED that the failure to file a verified Answer may subject you to being held in default. If you are held in default, the Board will assume the allegation to be true and will issue a recommendation based upon those facts without a hearing being held. These proceedings are held pursuant to the jurisdiction granted to the Department to investigate complaints and to bring this action pursuant to 20 Ill. Comp. Stat. 2105-15(a)(5) and 225 Ill. Comp. Stat. 60/36 (2006 as amended).


PLEASE BE ADVISED THAT YOU WILL HAVE TO SHOW A STATE ISSUED PHOTO IDENTIFICATION AND GO THROUGH A METAL DETECTOR IN ORDER TO GAIN ACCESS TO THE BUILDING.

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION OF THE STATE OF ILLINOIS, DIVISION OF PROFESSIONAL REGULATION

By: [Signature]
Frank Lamas
Chief of Health-Related Prosecutions

Brandon Thom/ck
Attorney, Health Related Prosecutions
IDFPR Division of Professional Regulation
100 W. Randolph St., Suite 9-300
Chicago, IL 60601
(312) 814-1693
Brandon.Tom@illinois.gov
Enf. ID: 2017-01360
Respondents: WESTMORELAND PHARMACY, 054.016721, 320.009596

2
STATE OF ILLINOIS

COUNTY OF COOK

SS: 2017-01360

UNDER PENALTY OF PERJURY, as provided by law, Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that I caused the attached Notice Preliminary Hearing and Complaint to be deposited in the United States mailbox located at 100 West Randolph Street, Chicago, Illinois 60601, and by mailing same by certified mail at 100 West Randolph Street, Chicago, Illinois, 60601, with proper postage prepaid to the parties at the addresses listed above, prior to 5:00 p.m. on the 22 day of January, 2018.

[Signature]
AFFIANT

Cert. Mail No: 7017 1070 0000 0339 4494
STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISION OF PROFESSIONAL REGULATION

DEPARTMENT OF FINANCIAL AND
PROFESSIONAL REGULATION, DIVISION OF
PROFESSIONAL REGULATION

of the State of Illinois,
Complainant,

v.

WESTMORELAND PHARMACY INC,
License No. 054.016721, 320.009596,
Respondent.

No. 2017-01360

COMPLAINT

NOW COMES THE DIVISION OF PROFESSIONAL REGULATION of the
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION of the State of
Illinois ("Department"), by its Chief of Health-Related Prosecutions, Frank Lamas, and as its
Complaint against WESTMORELAND PHARMACY, INC, Respondent, complains as follows:

COUNT I
UNLICENSED PRACTICE

1. The Department has the legal power and duty to investigate the conduct of licensees and
   take disciplinary action in administration and enforcement of the Illinois Pharmacy
   Practice Act, 225 ILCS 85/1 et seq., and the Rules adopted by the Department in
   furtherance of the Act, 68 Ill. Admin. Code § 1330.10 et seq.

2. WESTMORELAND PHARMACY, INC (hereinafter "Respondent Pharmacy") is the
   holder of a Pharmacy license in the State of Illinois, License Number 054.016721.

3. Respondent Pharmacy is the holder of a Controlled Substance License, License Number
   320.009596, in the State of Illinois issued by the Department.

4. On or about March 31, 2016, Respondent’s pharmacy license expired.

5. On or about March 31, 2016, Respondent’s Controlled Substance license expired.

6. Respondent Pharmacy practiced with a non-renewed pharmacy license from April 1,
   2016 to September 4, 2016.
7. Respondent Pharmacy practiced with a non-renewed Controlled Substance license from April 1, 2016 to September 4, 2016.


9. Respondent Pharmacy has engaged in the unlicensed practice of Pharmacy and unlicensed dispensing of controlled substances in the State of Illinois.


11. The foregoing acts, omissions, and violations are grounds for discipline pursuant to 225 ILCS 85/30 (a)(2), 225 ILCS 85/30 (a)(4), 225 ILCS 85/30 (a)(7), and 720 ILCS 570/304(a)(5).

WHEREFORE, based on the foregoing allegations, the Department of Financial and Professional Regulation of the State of Illinois, Division of Professional Regulation, by Frank Lamas, its Chief of Health-Related Prosecutions, prays that the Pharmacy license of WESTMORELAND PHARMACY, INC, License No. 054.016721, be suspended, revoked, or otherwise disciplined and that Respondent be fined an amount not to exceed $10,000 per violation in accordance with the Illinois Pharmacy Practice Act; and that the Illinois Controlled Substance License of WESTMORELAND PHARMACY, INC, License No. 320.009596, be suspended, revoked, or otherwise disciplined and that Respondent be fined an amount not to exceed $10,000 per violation in accordance with the Illinois Controlled Substances Act.

COUNT II
UNPROFESSIONAL CONDUCT

1-9. The Department repeats and realleges paragraphs 1 through 9 of Count I as paragraphs 1 through 9 of this Count as if the same were fully stated herein.

10. Respondent Non-Resident Pharmacy engaged in unprofessional conduct by dispensing medications to Illinois Residents when it had not renewed its Illinois pharmacy license.
11. The foregoing acts or omissions are in violation of 225 ILCS 85/5.5(a), 225 ILCS 85/30 (a)(2), 225 ILCS 85/30 (a)(4), 225 ILCS 85/30 (a)(7), and 68 Ill. Admin. Code 1330.30.

12. The foregoing acts, omissions, and violations are grounds for discipline pursuant to 225 ILCS 85/5.5(a), 225 ILCS 85/30 (a)(2), 225 ILCS 85/30 (a)(4), and 225 ILCS 85/30 (a)(7).

WHEREFORE, based on the foregoing allegations, the Department of Financial and Professional Regulation of the State of Illinois, Division of Professional Regulation, by Frank Lamas, its Chief of Health-Related Prosecutions, prays that the Pharmacy license of WESTMORELAND PHARMACY, INC, License No. 054.016721, be suspended, revoked, or otherwise disciplined and that Respondent be fined an amount not to exceed $10,000 per violation in accordance with the Illinois Pharmacy Practice Act.

DEPARTMENT OF FINANCIAL AND
PROFESSIONAL REGULATION of the State of Illinois
DIVISION OF PROFESSIONAL REGULATION

By:  
Frank Lamas  
Chief of Health-Related Prosecutions

Brandon Thom  
Attorney, Health Related Prosecutions  
IDFPR Division of Professional Regulation  
100 W. Randolph St., Suite 9-300  
Chicago, IL 60601  
(312) 814-1693  
Brandon.Thom@illinois.gov  
Enf. ID: 2017-01360  
Respondents: WESTMORELAND PHARMACY, 054.016721, 320.009596