

A

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: ALLCARE PHARMACY, INC.

Physical Address: 12 PLYMOUTH STREET, SUITE 100

Mailing Address: 12 PLYMOUTH STREET, SUITE 100

City: WORCESTER State: MASSACHUSETTS Zip Code: 01608-2121

Telephone: 508-754-8800 Fax: 508-754-8878

Toll Free Number: 1-855-716-3563 (Required per NAC 639.708)

E-mail: AREN.LEIGHTON@RXALLCARE.COM Website: HTTPS://WWW.RXALLCARE.COM

Managing Pharmacist: PAUL LENZ License Number: PH25313

TYPE OF PHARMACY AND

SERVICES PROVIDED

Yes/No

- Retail
- Hospital (# beds _____)
- Internet
- Nuclear
- Ambulatory Surgery Center
- Community
- Other: _____

All boxes must be checked
For the application to be complete

Yes/No

- Off-site Cognitive Services
- Parenteral **
- Parenteral (outpatient)
- Outpatient/Discharge
- Mail Service
- Long Term Care
- Sterile Compounding **
- Non Sterile Compounding
- Mail Service Sterile Compounding **
- Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

93518

B

NEVADA STATE BOARD OF PHARMACY

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Application form section with checkboxes for ownership types: New Pharmacy, Ownership Change, Publicly Traded Corporation, Partnership, Non Publicly Traded Corporation, Sole Owner.

GENERAL INFORMATION to be completed by all types of ownership

General information form fields: Pharmacy Name, Physical Address, Mailing Address, City, State, Zip Code, Telephone, Fax, Toll Free Number, E-mail, Website, Managing Pharmacist, License Number.

TYPE OF PHARMACY AND SERVICES PROVIDED section with checkboxes for various pharmacy types and services.

**If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,

93581

C

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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: Heritage Biologics, Inc
Physical Address: 255 NW Victoria Drive
Mailing Address: 255 NW Victoria Drive
City: Lee's Summit State: MO Zip Code: 64086
Telephone: 816-875-5101 Fax: 844-878-6917
Toll Free Number: 855-937-7273 (Required per NAC 639.708)
E-mail: hskelton@heritagebiologics.com Website: www.heritagebiologics.com
Managing Pharmacist: Holly S Skelton License Number: 2010023011

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	AND	Yes/No
<input type="checkbox"/> <input checked="" type="checkbox"/> Retail		<input type="checkbox"/> <input checked="" type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> <input checked="" type="checkbox"/> Hospital (# beds _____)		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral **
<input type="checkbox"/> <input checked="" type="checkbox"/> Internet		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> <input checked="" type="checkbox"/> Nuclear		<input type="checkbox"/> <input checked="" type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> <input checked="" type="checkbox"/> Ambulatory Surgery Center		<input checked="" type="checkbox"/> <input type="checkbox"/> Mail Service
<input type="checkbox"/> <input checked="" type="checkbox"/> Community		<input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care
<input checked="" type="checkbox"/> <input type="checkbox"/> Other: <u>Specialty</u>		<input type="checkbox"/> <input checked="" type="checkbox"/> Sterile Compounding **
		<input type="checkbox"/> <input checked="" type="checkbox"/> Non Sterile Compounding
		<input type="checkbox"/> <input checked="" type="checkbox"/> Mail Service Sterile Compounding **
		<input type="checkbox"/> <input type="checkbox"/> Other Services: _____

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,

93384

D

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 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: Paragon Healthcare Specialty
 Physical Address: 17111 Preston Rd., Ste 100
 Mailing Address: 17111 Preston Rd., Ste 100
 City: Dallas State: TX Zip Code: 75248-1234
 Telephone: 888-588-1072 Fax: 866-388-1488
 Toll Free Number: 888-588-1072 (Required per NAC 639.708)
 E-mail: eh@paragonhealthcare.com Website: www.paragonspecialty.com
 Managing Pharmacist: Eric Dustin Ho License Number: SI668(TX)

TYPE OF PHARMACY	AND	SERVICES PROVIDED
Yes/No		Yes/No
<input checked="" type="checkbox"/> <input type="checkbox"/> Retail		<input type="checkbox"/> <input checked="" type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> <input checked="" type="checkbox"/> Hospital (# beds _____)		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral **
<input type="checkbox"/> <input checked="" type="checkbox"/> Internet		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> <input checked="" type="checkbox"/> Nuclear		<input checked="" type="checkbox"/> <input type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> <input checked="" type="checkbox"/> Ambulatory Surgery Center		<input checked="" type="checkbox"/> <input type="checkbox"/> Mail Service
<input type="checkbox"/> <input checked="" type="checkbox"/> Community		<input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care
<input type="checkbox"/> <input checked="" type="checkbox"/> Other: _____		<input type="checkbox"/> <input checked="" type="checkbox"/> Sterile Compounding **
		<input type="checkbox"/> <input checked="" type="checkbox"/> Non Sterile Compounding
		<input type="checkbox"/> <input checked="" type="checkbox"/> Mail Service Sterile Compounding **
		<input checked="" type="checkbox"/> <input type="checkbox"/> Other Services: <u>Hemophilia</u>

All boxes must be checked
 For the application to be complete

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93711

E

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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: Pioneer Pharmaceuticals, LLC

Physical Address: 5101 Avenue H, #18

Mailing Address: 5101 Avenue H, #18

City: Rosenberg State: TX Zip Code: 77471

Telephone: 832.759.5114 Fax: 832.759.5115

Toll Free Number: 8779261650 (Required per NAC 639.708)

E-mail: christinap@pharmlicensing.com N/A

Managing Pharmacist: Joseph Hall License Number: 16754

TYPE OF PHARMACY AND SERVICES PROVIDED

TYPE OF PHARMACY	AND	SERVICES PROVIDED
Yes/No		Yes/No
<input checked="" type="checkbox"/> <input type="checkbox"/> Retail		<input type="checkbox"/> <input checked="" type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> <input checked="" type="checkbox"/> Hospital (# beds _____)		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral **
<input type="checkbox"/> <input checked="" type="checkbox"/> Internet		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> <input checked="" type="checkbox"/> Nuclear		<input type="checkbox"/> <input checked="" type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> <input checked="" type="checkbox"/> Ambulatory Surgery Center		<input checked="" type="checkbox"/> <input type="checkbox"/> Mail Service
<input checked="" type="checkbox"/> <input type="checkbox"/> Community		<input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care
<input type="checkbox"/> <input checked="" type="checkbox"/> Other: _____		<input type="checkbox"/> <input checked="" type="checkbox"/> Sterile Compounding **
		<input type="checkbox"/> <input checked="" type="checkbox"/> Non Sterile Compounding
		<input type="checkbox"/> <input checked="" type="checkbox"/> Mail Service Sterile Compounding **
		<input checked="" type="checkbox"/> <input type="checkbox"/> Other Services: <u>DME</u>

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,

93579

F

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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: Priority Care Pharmacy Services, LLC

Physical Address: 11000 Highland Drive

Mailing Address: 11000 Highland Drive

City: Amory State: MS Zip Code: 38821

Telephone: 888-333-1290 Fax: (877)828-4330

Toll Free Number: 888-333-1290 (Required per NAC 639.708)

E-mail: pharmacy@prioritycarerx.net Website: _____

Managing Pharmacist: William H. Austin License Number: E-07344

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	AND	Yes/No
<input checked="" type="checkbox"/> <input type="checkbox"/> Retail		<input type="checkbox"/> <input checked="" type="checkbox"/> Other: _____
<input type="checkbox"/> <input checked="" type="checkbox"/> Hospital (# beds _____)		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral **
<input type="checkbox"/> <input checked="" type="checkbox"/> Internet		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> <input checked="" type="checkbox"/> Nuclear		<input type="checkbox"/> <input checked="" type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> <input checked="" type="checkbox"/> Ambulatory Surgery Center		<input checked="" type="checkbox"/> <input type="checkbox"/> Mail Service
<input checked="" type="checkbox"/> <input type="checkbox"/> Community		<input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care
<input type="checkbox"/> <input checked="" type="checkbox"/> Other: _____		<input type="checkbox"/> <input checked="" type="checkbox"/> Sterile Compounding **
		<input type="checkbox"/> <input checked="" type="checkbox"/> Non Sterile Compounding
		<input type="checkbox"/> <input checked="" type="checkbox"/> Mail Service Sterile Compounding **
		<input type="checkbox"/> <input checked="" type="checkbox"/> Other Services: _____

All boxes must be checked
For the application to be complete

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93417

G

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[X] New Pharmacy or [] Ownership Change (Provide current license number if making changes: PH ____
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[] Publicly Traded Corporation - Pages 1,2,3,7 [] Partnership - Pages 1,2,5,7
[X] 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: ProCare Pharmacy Care, LLC
Physical Address: 3891 Commerce Parkway
Mailing Address: 3891 Commerce Parkway
City: Miramar State: FL Zip Code: 33025
Telephone: 800-662-0586 Fax: 800-662-0590
Toll Free Number: 800-662-0586 (Required per NAC 639.708)
E-mail: dsawh@procarerx.com Website: www.procarerx.com
Managing Pharmacist: Daven Sawh License Number: PS47900

Table with 2 columns: TYPE OF PHARMACY AND SERVICES PROVIDED. Includes checkboxes for Retail, Hospital, Internet, Nuclear, Ambulatory Surgery Center, Community, Other, Off-site Cognitive Services, Parenteral, Outpatient/Discharge, Mail Service, Long Term Care, Sterile Compounding, Non Sterile Compounding, Mail Service Sterile Compounding, and Other Services.

**If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,

93646

H

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Check box below for type of ownership and complete all required forms.

Publicly Traded Corporation – Pages 1,2,3,7

Partnership ^{Limited} – 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: Recept Pharmacy #1

Physical Address: 800 8th Ave., Ste. 130 Fort Worth, TX 76104

Mailing Address: 1620 W. Northwest Hwy, Ste. 100

City: grapevine State: TX Zip Code: 76051

Telephone: 817-335-5712 Fax: 817-332-5363

Toll Free Number: 866-326-1425 (Required per NAC 639.708)

E-mail: tammie@receptrx.com Website: receptrx.com

Managing Pharmacist: Wesley Skalak License Number: 43221/23060

TYPE OF PHARMACY AND

SERVICES PROVIDED

Yes/No

- Retail
- Hospital (# beds _____)
- Internet
- Nuclear
- Ambulatory Surgery Center
- Community
- Other: _____

All boxes must be checked
For the application to be complete

Yes/No

- Off-site Cognitive Services
- Parenteral **
- Parenteral (outpatient)
- Outpatient/Discharge
- Mail Service
- Long Term Care
- Sterile Compounding **
- Non Sterile Compounding
- Mail Service Sterile Compounding **
- Other Services: _____

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93603

I

NEVADA STATE BOARD OF PHARMACY

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New Pharmacy or Ownership Change (Provide current license number if making changes: PH 02879)
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: VALLEY CAMPUS PHARMACY, INC. dba TNH PHARMACY 2

Physical Address: 15211 VANOWEN STREET SUITE 301 VAN NUYS, CA 91405

Mailing Address: ATTN: LICENSING 4100 S. SAGINAW ST.

City: FLINT State: MI Zip Code: 48507

Telephone: 818-988-1288 Fax: 855-356-1096

Toll Free Number: 877-849-9591 (Required per NAC 639.708)

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

Managing Pharmacist: HAGOP SIMITYAN License Number: RPH 65882

TYPE OF PHARMACY

AND

SERVICES PROVIDED

Yes/No

- Retail
- Hospital (# beds _____)
- Internet
- Nuclear
- Ambulatory Surgery Center
- Community
- Other: _____

All boxes must be checked
For the application to be complete

Yes/No

- Off-site Cognitive Services
- Parenteral **
- Parenteral (outpatient)
- Outpatient/Discharge
- Mail Service
- Long Term Care
- Sterile Compounding **
- Non Sterile Compounding
- Mail Service Sterile Compounding **
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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: Wecare Pharmaceutical Services Inc.

Physical Address: 2121 North D Street San Bernardino CA 92405

Mailing Address: 2121 North D Street

City: San Bernardino State: CA Zip Code: 92405

Telephone: (909) 693-3376 Fax: (909) 494-5582

Toll Free Number: (877) 301-0636 (Required per NAC 639.708)

E-mail: Erik Tran@Rxwecare.com Website: www.rxwecare.com

Managing Pharmacist: Hong Tran License Number: 52824

TYPE OF PHARMACY AND

SERVICES PROVIDED

Yes/No

- Retail
- Hospital (# beds _____)
- Internet
- Nuclear
- Ambulatory Surgery Center
- Community
- Other: _____

All boxes must be checked
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Yes/No

- Off-site Cognitive Services
- Parenteral **
- Parenteral (outpatient)
- Outpatient/Discharge
- Mail Service
- Long Term Care
- Sterile Compounding **
- Non Sterile Compounding
- Mail Service Sterile Compounding **
- Other Services: _____

**If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,

093602

K

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Partnership - Pages 1,2,5,7

Non Publicly Traded Corporation – Pages 1,2,4,7

Sole Owner – Pages 1,2,6,7

LLC

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Farre's Baytown Pharmacy

Physical Address: 620 Blue Meadow Rd., Bay St. Louis, MS 39520

Mailing Address: Same

City: _____ State: _____ Zip Code: _____

Telephone: 228-220-1050 Fax: 228-467-4638

Toll Free Number: 855-853-9390 (Required per NAC 639.708)

E-mail: bmarcia@baytownpharmacy.com Website: _____

Managing Pharmacist: William A. Marcia License Number: T-010844

TYPE OF PHARMACY

AND

SERVICES PROVIDED

Yes/No

- Retail
- Hospital (# beds _____)
- Internet
- Nuclear
- Ambulatory Surgery Center
- Community
- Other: _____

All boxes must be checked
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Yes/No

- Off-site Cognitive Services
- Parenteral **
- Parenteral (outpatient)
- Outpatient/Discharge
- Mail Service
- Long Term Care
- Sterile Compounding **
- Non Sterile Compounding
- Mail Service Sterile Compounding **
- Other Services: _____

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