

**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: CALIFORNIA SPECIALTY PHARMACY

Physical Address: 12466 E WASHINGTON BLVD

Mailing Address: 12466 E WASHINGTON BLVD

City: Whittier State: CA Zip Code: 90602

Telephone: 877-602-7779 Fax: 866-853-6555

Toll Free Number: 877-602-7779 (Required per NAC 639.708)

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

Managing Pharmacist: ETHAN HUYNH License Number: 58232

**TYPE OF PHARMACY AND SERVICES PROVIDED**

<p>Yes/No</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Retail</p> <p><input type="checkbox"/> <input type="checkbox"/> Hospital (# beds _____)</p> <p><input type="checkbox"/> <input type="checkbox"/> Internet</p> <p><input type="checkbox"/> <input type="checkbox"/> Nuclear</p> <p><input type="checkbox"/> <input type="checkbox"/> Ambulatory Surgery Center</p> <p><input type="checkbox"/> <input type="checkbox"/> Community</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Other: <u>Home Infusion</u></p> <p>All boxes must be checked For the application to be complete</p>	<p>Yes/No</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Off-site Cognitive Services</p> <p><input type="checkbox"/> <input type="checkbox"/> Parenteral **</p> <p><input type="checkbox"/> <input type="checkbox"/> Parenteral (outpatient)</p> <p><input type="checkbox"/> <input type="checkbox"/> Outpatient/Discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> Mail Service</p> <p><input type="checkbox"/> <input type="checkbox"/> Long Term Care</p> <p><input type="checkbox"/> <input type="checkbox"/> Sterile Compounding **</p> <p><input type="checkbox"/> <input type="checkbox"/> Non Sterile Compounding</p> <p><input type="checkbox"/> <input type="checkbox"/> Mail Service Sterile Compounding **</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Other Services: <u>Specialty Pharmacy</u></p>
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**\*\*If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

92853

# APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

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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

Ethan Huynh, PharmD  
Print Name of Authorized Person

05/10/2016  
Date

Board Use Only	Date Processed: <u>5.19.16</u>	Amount: <u>\$ 500.00</u>
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APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

**OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION**

State of Incorporation: California

Parent Company if any: N/A

Mailing Address: 12466 E WASHINGTON BLVD

City: Whittier State: CA Zip: 90601

Telephone: 877-602-7779 Fax: 866-853-6555

Contact Person: Ethan Huynh, PharmD

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

a) ANIL BADLANI 12620 Liddington St Cerritos, Ca 90703  
Name Address

b) BHAVESH DESAI 1823 Commercenter Drive San Bernardino, CA 92408  
Name Address

c) SUMIT DESAI 1823 Commercenter Drive San Bernardino, CA 92408  
Name Address

d) \_\_\_\_\_  
Name Address

2) Provide the number of shares issued by the corporation. 900,000

3) What was the price paid per share? \$0.667

4) What date did the corporation actually receive the cash assets? 03/09/2010

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 9:00 am 5:00 pm Saturday CLOSED am \_\_\_\_\_ pm  
Sunday CLOSED am \_\_\_\_\_ pm 24 Hours \_\_\_\_\_

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: \_\_\_\_\_

**Out of State Pharmacy applicant - Change of Address**

Ethan Huynh [ethan@csprx.com]

**Sent:** Tuesday, August 9, 2016 9:43 AM**To:** Pharmacy Board**Cc:** Sumit Desai [sumit@csprx.com]; Bhavesh Desai [bdesai@guardianrx.us]; George Kridner [george@csprx.com]**Attachments:** CA PHY 54320 Retail Pharma~1.pdf (5 MB)

Dear Candy/Licensing team,

Thank you for taking my call this morning. From our conversation, since our application is still pending final approval and our address location has changed this is to notify BOP that our address has changed from 12466 E WASHINGTON BLD, WHITTIER, CA 90602 to our new address: **13027 HADLEY ST, SUITE B, WHITTIER CA 90601.**

Attached also is our new issued permit from CA BOP reflecting the new and current address.

Please ensure that the letter being issued to notify us of the details regarding the appearance for the September Board meeting is sent to 13027 Hadley St, Suite B, Whittier CA 90601.

Thank you,

***Ethan Huynh, Pharm.D.***

Vice President, Pharmacy Operations

**California Specialty Pharmacy**

13027 Hadley St, Suite B

Whittier, CA 90601

Phone (877) 602-7779 | Fax (866) 853-6555

[www.csprx.com](http://www.csprx.com)

"Discover the difference of an independent specialty pharmacy"

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

STATEMENT OF RESPONSIBILITY  
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Ethan Huynh, PharmD

Responsible Person of CALIFORNIA SPECIALTY PHARMACY

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

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

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



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

Ethan Huynh, PharmD

Print Name of Authorized Person

05/10/2016  
Date



**California State Board of Pharmacy**

1625 N. Market Blvd, N219, Sacramento, CA 95834  
Phone: (916) 574-7900  
Fax: (916) 574-8618  
www.pharmacy.ca.gov

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY  
DEPARTMENT OF CONSUMER AFFAIRS  
GOVERNOR EDMUND G. BROWN JR.

May 10, 2016

CALIFORNIA SPECIALTY PHARMACY  
12466 E WASHINGTON BLVD  
WHITTIER CA 90602

**California State Board of Pharmacy License Verification**

This document reflects the license status of the person or entity identified below on this date with the California State Board of Pharmacy. It may be used as prima facie evidence of the facts recited below pursuant to California Business and Professions Code section 162.

**Licensee Name:** CALIFORNIA SPECIALTY PHARMACY

**License Type:** PHARMACY

**License Number:** PHY 50315

**Status:** ACTIVE

**Issue Date:** 06/24/10

**Expiration Date:** 06/01/16

**Address of Record:** 12466 E WASHINGTON BLVD WHITTIER CA 90602

**Disciplinary Action:** NO RECORD OF DISCIPLINARY ACTION

Virginia Herold  
Executive Officer

By

A handwritten signature in blue ink that reads "Barbera Schleicher". The signature is written in a cursive style and is positioned to the right of the word "By".

Barbera Schleicher  
Public Inquiry Analyst  
(916) 574-7922

Barbera.Schleicher@dca.ca.gov

**NEVADA STATE BOARD OF PHARMACY**  
 431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440  
**APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE**

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<input type="checkbox"/> New Pharmacy	<input checked="" type="checkbox"/> Ownership Change (Please provide current license number if making changes: <u>PH02510</u> )
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7	<input type="checkbox"/> Partnership - Pages 1,2,5,7
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7

Please check box for type of ownership and complete correct part of the application.

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

Pharmacy Name: R4R Compounding, DBA Talon Compounding  
 Physical Address: 2950 Thousand Oaks  
 Mailing Address: Same  
 City: San Antonio State: TX Zip Code: 78232  
 Telephone: 210 424 0025 Fax: 210 424 -0026  
 Toll Free Number: 800 250 6232 (Required per NAC 639.708)  
 E-mail: pharmacy@taloncompounding.com Website: taloncompounding.com  
 Managing Pharmacist: Rachel Pittman License Number: 51474

**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"/> 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 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

**\*\*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-OFSTATE PHARMACY LICENSE**

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- 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 or proceeding relating to the pharmaceutical industry? Yes  No
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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.

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

Ronda Wenzel  
Print Name of Authorized Person

5-23-16  
Date

<b>Board Use Only</b>	Received: _____	Amount: <u>\$500.00</u>
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APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

**OWNERSHIP IS A PARTNERSHIP**

General \_\_\_\_\_

Limited

Partnership Name: R & R Compounding, LLC

Mailing Address: 2950 Thousand Oaks Dr. Ste. 25

City, State Zip Code: San Antonio, TX 78232

Telephone Number: 210 424 0025 Fax Number: 210 424 0026

Contact Person: Ronda Wenzel

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

<u>Name</u>	<u>G or L</u>	<u>Percentage</u>
<u>Rachel Suzanne Pittman</u>	<u>L</u>	<u>51</u>
<u>Ronda Melyn Wenzel</u>	<u>L</u>	<u>49</u>

List names of 4 largest partners and percentage of ownership: no others

Name: \_\_\_\_\_ %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

List any physician shareholders and percentage of ownership. none

Name: \_\_\_\_\_ %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

\* we are an LLC, we've used the "partnership" form because it seemed to fit

CORPORATE STATEMENT OF RESPONSIBILITY  
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Ronda Wenzel

Responsible Person of R & R Compounding

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.

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Ronda Wenzel

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

Ronda Wenzel

Print Name of Authorized Person

5-23-16

Date

# NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

## APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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New Pharmacy or  Ownership Change (Provide current license number if making changes: PH 02133)

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: US Compounding

Physical Address: 1270 Dons Lane Conway, AR 72032

Mailing Address: P.O. Box 2709 Conway, AR 72033

City: Conway State: AR Zip Code: \_\_\_\_\_

Telephone: 501-327-1222 Fax: 501-499-8383

Toll Free Number: (800) 718-3588 (Required per NAC 639.708)

E-mail: licensing@uscompounding.com Website: www.uscompounding.com

Managing Pharmacist: Eddie Glover License Number: PD06232

#### TYPE OF PHARMACY

AND

#### SERVICES PROVIDED

Yes/No

- Retail  
  Hospital (# beds \_\_\_\_\_)  
  Internet  
  Nuclear  
  Ambulatory Surgery Center  
  Community  
  Other: 503B

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: \_\_\_\_\_

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.

*no change from previous business model*

# APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

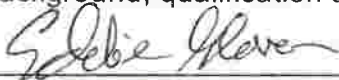
Within the last five (5) years:

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

Eddie Glover

Print Name of Authorized Person

5/31/16  
**Date**

Page 2

**Board Use Only**

Date Processed: \_\_\_\_\_

Amount: \$500.00