

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: American Specialty Pharmacy

Physical Address: 10 Medical Pkwy, Ste 105, Farmers Branch, Tx 75234

Mailing Address: 2733 W 15th Street

City: Plano State: Texas Zip Code: 75075

Telephone: 214-432-4422 Fax: 972-243-3260

Toll Free Number: 888-495-8215 (Required per NAC 639.708)

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

Managing Pharmacist: Jessica Stapleton License Number: 49734

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,

91186

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

Abdul Hameed

Print Name of Authorized Person

8/31/15

Date

Page 2

Board Use Only

Date Processed: 12-7-15

Amount: \$500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: Texas
Parent Company if any: n/a
Mailing Address: 2733 W 15th Street
City: Plano State: TX Zip: 75075
Telephone: 214-919-2520 Fax: 214-919-2524
Contact Person: Monica Penn

For any corporation non publicly traded, disclose the following:

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

a) Abdul Hameed 3619 Crescent Ave Dallas, Tx 75205
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. 1,000,000

3) What was the price paid per share? \$1.001

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: none %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 5 pm Saturday Closed am _____ pm
Sunday Closed 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

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: Abdul Hameed
Business Name: American Specialty Pharmacy
Current Business Address: 2733 W 15th Street
City: Plano State: TX Zip Code: 75075
Telephone: 214-919-2520 Fax: 214-919-2524

List any physician shareholders and percentage of ownership.

Name: Abdul Hameed %: 100
Name: _____ %: _____
Name: _____ %: _____
Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 5 pm Saturday Closed am _____ pm
Sunday Closed am _____ pm 24 Hours N/A

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

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Abdul Hameed
Responsible Person of American 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

Abdul Hameed

Print Name of Authorized Person

8/31/15

Date



TEXAS STATE BOARD OF PHARMACY

Jeanne D. Waggener, R.Ph.
President
Waco

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Vice President
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Abilene

Joyce A. Tipton, R.Ph.
Houston

Charles F. Wetherbee
Boerne

Dennis F. Wiesner, R.Ph.
Austin

Gay Dodson, R.Ph.
Executive Director Secretary
Austin

Re: American Specialty Pharmacy

Address: 10 Medical Parkway, Suite 105
Farmers Branch, Texas 75234

License No.: 29107

Date Issued: March 25, 2014

Licensure Status: Active

Expiration Date: March 31, 2016

Type of Pharmacy: Community – Class A

Prior Disciplinary Orders: No

The Texas State Board of Pharmacy maintains records regarding licensure and disciplinary action against a licensee. American Specialty Pharmacy (Texas Pharmacy License #29107) has not been subject to disciplinary action by the Texas State Board of Pharmacy.

Form Completed by:

Allison Benz, R.Ph., M.S.
Director of Professional Services
Texas State Board of Pharmacy

June 5, 2015
Date



The Texas Department of State Health Services, Drugs and Medical Devices Division, Wholesaler Registration, 1100 W. 49th Street, Austin, TX 78756, is responsible for issuing registrations to wholesale drug distributors and drug manufacturers in Texas.

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

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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: American Specialty Pharmacy

Physical Address: 2414 Babcock Rd, Ste 106 San Antonio, TX 78229

Mailing Address: 2733 W 15th Street

City: Plano State: Texas Zip Code: 75075

Telephone: 210-417-4567 Fax: 210-858-6007

Toll Free Number: 888-412-5929 (Required per NAC 639.708)

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

Managing Pharmacist: Krista Garcia License Number: 51824

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,

a1338

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

Abdul Hameed
Print Name of Authorized Person

11/18/2015
Date

Page 2

Board Use Only

Date Processed: _____

Amount: \$500.00

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: Abdul Hameed

Business Name: American Specialty Pharmacy

Current Business Address: 2733 W 15th Street

City: Plano State: Texas Zip Code: 75075

Telephone: 214-919-2520 Fax: 214-919-2524

List any physician shareholders and percentage of ownership.

Name: Abdul Hameed %: 100

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 5 pm

Saturday Closed am _____ pm

Sunday Closed am _____ pm

24 Hours N/A

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

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Abdul Hameed

Responsible Person of American 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

Abdul Hameed
Print Name of Authorized Person

11/18/2015
Date



TEXAS STATE BOARD OF PHARMACY

Re: American Specialty Pharmacy

Address: 2414 Babcock Road, Suite 106
San Antonio, Texas 78229

License No.: 29664

Date Issued: November 26, 2014

Licensure Status: Active

Expiration Date: November 30, 2016

Type of Pharmacy: Community Sterile Compounding

Prior Disciplinary Orders: No

The Texas State Board of Pharmacy maintains records regarding licensure and disciplinary action against a licensee. American Specialty Pharmacy (Texas Pharmacy License #29664) has not been subject to disciplinary action by the Texas State Board of Pharmacy.

Form Completed by:

A handwritten signature in cursive script, reading "Margarita Zamarripa", is written over a horizontal line.

Margarita Zamarripa
Senior Administrative Assistant
Professional Services
Texas State Board of Pharmacy



November 17, 2015
Date

The Texas Department of State Health Services, Drugs and Medical Devices Division, Wholesaler Registration, 1100 W. 49th Street, Austin, TX 78756, is responsible for issuing registrations to wholesale drug distributors and drug manufacturers in Texas.

Blank

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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

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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: Care Solutions, Inc.

Physical Address: 1838 Elm Hill Pike, Suite 117

Mailing Address: 1838 Elm Hill Pike, Suite 117

City: Nashville State: TN Zip Code: 37210

Telephone: 615-329-2288 Fax: 615-333-8431

Toll Free Number: 800-830-4321 (Required per NAC 639.708)

E-mail: pharmen@caresolution.net Website: _____

Managing Pharmacist: Pamela Flohr License Number: 3931

TYPE OF PHARMACY

AND

SERVICES PROVIDED

Yes/No

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

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,**

90765

APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

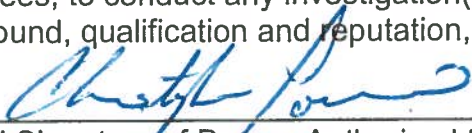
Within the last five (5) years:

- 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 ☒
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- 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 ☒

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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

Christopher Powers

Print Name of Authorized Person

10.20.15

Date

Page 2

Board Use Only

Date Processed: _____

Amount: \$500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: Florida
Parent Company if any: N/A
Mailing Address: 1838 Elm Hill Pike, Suite 117
City: Nashville State: TN Zip: 37210
Telephone: 615-329-2288 Fax: 615-333-8431
Contact Person: Pamala Harmon

For any corporation non publicly traded, disclose the following:

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

a) Timothy Powers 1821 Legion Drive Winter Park, FL 32789
Name Address
b) Andrew Miller 7944 Fisher Island Drive Miami, FL 33109
Name Address
c) N/A
Name Address
d) N/A
Name Address

- 2) Provide the number of shares issued by the corporation. 300
3) What was the price paid per share? \$.01
4) What date did the corporation actually receive the cash assets? May 6, 1992
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 am 5 pm Saturday PRN am _____ pm
Sunday PRN am _____ pm 24 Hours X RPh available

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



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 Mainstream Drive, Second Floor
Nashville, TN 37243
<http://tn.gov/health>

Tennessee Board of Pharmacy
Pharmacy
1-800-778-4123 or

October 21, 2015

Care Solutions, Inc.
1838 Elm Hill Pike, Ste. 117
Nashville, TN 37210-3726

TO WHOM IT MAY CONCERN:

This verification can be considered primary source. To expedite the verification process, this is the standard format used by the Tennessee Board of Pharmacy. We are pleased to furnish the following information from our files:

PROFESSION: Pharmacy
NAME: Care Solutions, Inc.
1838 Elm Hill Pike, Ste. 117
Nashville, TN 37210
LICENSE NUMBER: 2325
ISSUE DATE: August 13, 1992
EXPIRATION DATE: October 31, 2016
CURRENT STATUS: Licensed
STATUS DATE: August 13, 1992
SPECIAL ENDORSEMENT: Controlled Substance Registration
Sterile Compounding



COMMENTS: There is derogatory information in our files concerning this facility. The State of Tennessee only provides the above information. Disciplinary information is available on our web site at <http://health.state.tn.us> or you may contact the licensee for further information.

Sincerely,

Tennessee Board of Pharmacy

VERFFACI.TY

BEFORE THE TENNESSEE STATE BOARD OF PHARMACY

IN THE MATTER OF:

**CARE SOLUTIONS, INC. #2325
5211 LINBAR DRIVE, SUITE 508
NASHVILLE, TN 37211**

)
)
)
)
) **Case No. 2014002301**
)

CONSENT ORDER

Comes now the Division of Health Related Boards of the Tennessee Department of Health (State), by and through the Office of General Counsel and Respondent, Care Solutions, Inc. (Respondent) and respectfully moves the Tennessee Board of Pharmacy (Board) for approval of this Consent Order affecting Respondent's pharmacy license in the State of Tennessee.

I. Authority and Jurisdiction

The Board regulates and supervises pharmacies, pharmacists, pharmacy technicians, and pharmaceutical manufacturers, wholesalers, and distributors licensed to practice pursuant to the Tennessee Pharmacy Practice Act (Practice Act), Tennessee Code Annotated Section (TENN. CODE ANN. §) 63-10-101, *et seq.*, including the discipline of licensees, as well as those who are required to be licensed, who violate the Practice Act and the Rules promulgated by the Board, Official Compilation of Rules and Regulations of the State of Tennessee (TENN. COMP. R. & REGS.), 1140-01-.01, *et seq.* The Board enforces the Practice Act to promote and protect the health, safety and welfare of the public; accordingly, it is the policy of the Board to require strict compliance with the law and to apply the law to preserve the quality of pharmacy care provided in Tennessee.

II. Stipulations of Fact

1. Respondent has been at all times pertinent hereto licensed by the Board as a pharmacy in

the State of Tennessee, having been granted license number 2325 on August 13, 1992, which currently has an expiration date of October 31, 2016.

2. On December 2, 2014, investigation revealed that Respondent relocated its facility to the Elm Hill Pike, Nashville, Tennessee location and had been doing business at that facility since November 19, 2014 without obtaining an inspection for the relocated facility.

III. Stipulated Grounds for Discipline

3. The State of Tennessee Board of Pharmacy has the authority to revoke, suspend, or impose other lawful disciplinary action, including a civil penalty for any violation of any laws relating to drugs or to the practice of pharmacy and/or the Board's rules pursuant to TENN. CODE ANN. §63-10-305, and TENN. COMP. R. & REG. 1140-08-.01 [CIVIL PENALTIES].
4. The Stipulations of Fact are sufficient to establish that Respondent has violated the following statutes or rules which are part of the Act, TENN. CODE ANN. § 63-10-101, *et seq.* and TENN. COMP. R. & REGS., 1140-01-.01, *et seq.*, for which disciplinary action by the Board is authorized.
5. The facts stipulated in paragraphs 2 and 3, *supra*, constitute grounds for which the Board may discipline a Respondent's license to practice pharmacy pursuant to Tenn. Comp. R. & Regs. 1140-01-.08 [APPLICATION FOR PHARMACY PRACTICE SITE, MANUFACTURER AND WHOLESALE/DISTRIBUTOR LICENSES], the relevant portion of which reads as follows:

(1) Application for a license to operate as a pharmacy practice site, manufacturer or wholesaler/distributor within the state of Tennessee shall be submitted to the office of the board at least thirty (30) days prior to the scheduled opening date. No pharmacy practice site, manufacturer or wholesaler/distributor may open within the state of Tennessee until

a license has been obtained; and such license will not be issued until an inspection by an authorized representative of the board has been made.

(2) An application for an existing pharmacy practice site, manufacturer or wholesaler/distributor physically located within the state of Tennessee must be filed when the pharmacy practice site, manufacturer or wholesaler/distributor changes name, location or ownership.

IV. Stipulated Disposition

6. Without admitting to the truth of the allegations herein or to any alleged failure to comply with a lawful order or duly promulgated rule in violation(s) of Tenn. Code Ann. § 63-10-305(8) and for the purpose of avoiding further administrative actions with respect to this cause, Respondent agrees to the following:

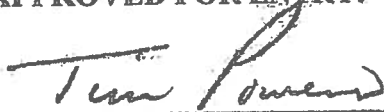
Respondent agrees to pay a **one thousand dollar (\$1,000.00) civil penalty** due and payable immediately upon execution of this Consent Order.

V. Notice


7. The Respondent, by its signature to this Consent Order, waives the right to a contested case hearing and any and all rights to judicial review in this matter. Respondent agrees that presentation to and consideration of this Consent Order by the Board for ratification and all matters divulged during that process shall not constitute unfair disclosure such that the Board or any of its members shall be prejudiced to the extent that requires their disqualification from hearing this matter should this Order not be ratified. Likewise, all matters, admissions and statements disclosed or exchanged during the attempted ratification process shall not be used against the Respondent in any subsequent proceeding unless independently entered into evidence or introduced as admissions.

8. Respondent expressly waives all further procedural steps and expressly waives all rights to seek judicial review of or to challenge or contest the validity of this Consent Order. Respondent understands that by signing this Consent Order, Respondent is allowing the Board to issue its order without further process. In the event that the Board rejects this Consent Order for any reason, it will be of no force or effect for either party.
9. Should this Consent Order not be accepted by the Board, it is agreed that the presentation and consideration of this Consent Order shall not unfairly or illegally prejudice the Board or any of its members from further participation in or resolution of these proceedings, including a formal disciplinary hearing.
10. Furthermore, Respondent acknowledges that they understand that they have a right to a hearing under the provisions of the Uniform Administrative Procedures Act, TENN. CODE ANN. Title 4, Chapter 5, but that they hereby waive that right in order to enter into this proposed Consent Order.
11. A **violation** of this Order shall constitute a **separate violation** of the Pharmacy Practice Act, TENN. CODE ANN. § 63-10-305(8), and is grounds for further disciplinary action by the Board.

APPROVED FOR ENTRY:


Representative of Care Solutions, Inc.
Pharmacy License No. 2325
Respondent

2/13/15
DATE


Stefan Cange (RPR # 031057)
Assistant General Counsel
Tennessee Department of Health
Office of General Counsel
665 Mainstream Drive, 2nd Floor
Nashville, Tennessee 37243
(615) 741-1611

3/16/15
DATE

Approval by the Board

Upon the agreement of the parties and the record as a whole, this **CONSENT ORDER** was approved as a **FINAL ORDER** by a majority of a quorum of the Tennessee Board of Pharmacy at a public meeting of the Board and signed this 11 day of March, 2015

ACCORDINGLY, IT IS ORDERED that the agreements of the parties will, and hereby do, become the Final Order of the Board.


Chairperson/Acting Chairperson
Tennessee Board of Pharmacy


STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Christopher Powers
Responsible Person of Care Solutions, Inc.

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

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

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


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

Christopher Powers
Print Name of Authorized Person

10.20.15
Date

This pharmacy has contacted the board and would like to postpone and will contact us for a future meeting.

Blank

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: Pharmakon Pharmaceuticals, Inc.

Physical Address: 14450 Getz Road

Mailing Address: Same as above

City: Noblesville State: IN Zip Code: 46060

Telephone: ³¹⁷~~888~~ 660-6715 Fax: 888-660-6716

Toll Free Number: 888-660-6715 (Required per NAC 639.708)

E-mail: Cbeardene@pharmakonrx.net Website: pharmakonmfg.net

Managing Pharmacist: Michelle Beland, RPh License Number: 26020308A

TYPE OF PHARMACY

AND

SERVICES PROVIDED

Yes/No

- ☐ ☒ Retail
☐ ☒ Hospital (# beds ____)
☐ ☒ Internet
☐ ☒ Nuclear
☐ ☒ Ambulatory Surgery Center
☐ ☒ Community
☒ ☐ Other: SOB Outsourcing

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,

91191

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.

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

Caprice Bearden
Print Name of Authorized Person

11/9/2015
Date

Page 2

Board Use Only

Date Processed: 12-9-15

Amount: \$500.00

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: Paul J Elmer, RPh

Business Name: Pharmakon Pharmaceuticals, Inc.

Current Business Address: 14450 Getz Road

City: Noblesville State: IN Zip Code: 46060

Telephone: 888-660-6715 Fax: 888-660-6716

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 7:30 am 5:30 pm

Saturday 8:00 am 12:00 pm

Sunday _____ am _____ pm

24 Hours _____

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

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

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

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

Caprice Bearden
Print Name of Authorized Person

11/9/2015
Date



465 N Roxbury Dr Suite 102
Beverly Hills, CA 90210
Phone: 310-273-1644
Fax: 310-276-4152

Non-Resident License Application

To Whom It May Concern:

Roxsan Pharmacy has had a recent Change of Ownership; therefore, we are re-registering so that we can continue to provide patient care services and ship medications to your state.

Our pharmacy provides retail, fertility, and compounded prescriptions. We take pride in being one of the few pharmacies in the nation that are contracted with EMD Serono; thereby, allowing us to obtain and provide fertility medications. During the years, Roxsan Pharmacy has established relationships and trust with both the patients and physicians within your state. We hope to continue to provide care and services to these patients utilizing these time-sensitive medications.

With the new ownership, we have made many changes to the pharmacy, including a new mission statement, an updated staff, with ongoing retraining of all team members. Also, we have in place a more extensive and improved Standard Operational Procedures handbook. Recently, we have had a change in Pharmacist In Charge (PIC) and appointed a new Compliance Officer. Thus far, we have made enormous strides in improving the pharmacy operation and compliance with the ever-changing pharmacy rules and regulations.

We kindly ask the Board to grant us an approval for registration so that we can continue to provide our patients with the uninterrupted services they require. We thank you for your time and consideration of our application. If you have any questions and/or inquiries, please do not hesitate to contact me.

Thank you again.

Sincerely,

A handwritten signature in cursive script that reads "Michael Rashti".

Michael Rashti
Pharmacist In Charge
RoxSan Pharmacy Inc.

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: Roxsan Pharmacy Inc.

Physical Address: 465 N. Roxbury Dr.

Mailing Address: Summit

City: Beverly Hills State: CA Zip Code: 90210

Telephone: (310) 273-1644 Fax: (310) 276-4152

Toll Free Number: (888) 371-9919 (Required per NAC 639.708)

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

Managing Pharmacist: Michael Rashti License Number: CA 58192

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,

91248

APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

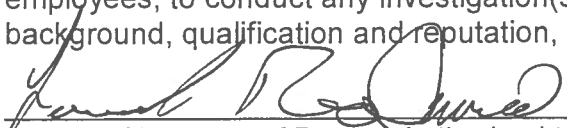
Within the last five (5) years:

- 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

Joseph Michael Redmond
Print Name of Authorized Person

11-18-15
Date

Page 2

Board Use Only

Date Processed: _____

Amount: \$500.00

OWNERSHIP IS A PUBLICLY TRADED CORPORATION

Page 3

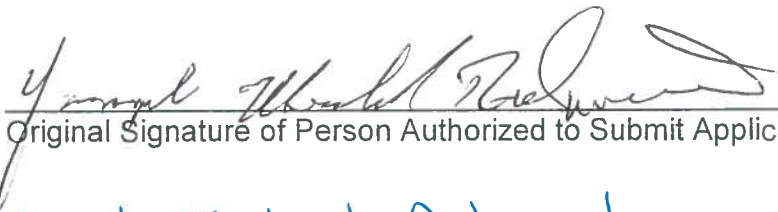
STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Joseph Michael Redmond
Responsible Person of Rossan Pharmacy Inc.

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

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

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



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

Joseph Michael Redmond

Print Name of Authorized Person

12-1-15

Date



California State Board of Pharmacy

1625 N. Market Blvd, Suite 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.

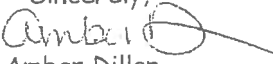
July 30, 2015

RE: PHY 52506
Roxsan Pharmacy, Inc
465 N Roxbury Dr
Beverly Hills, Ca 90210

License PHY 52506 is current and in good standing. No adverse action has been taken against this license. The license information is as follows:

LICENSE:	PHY
LICENSE NO:	52506
ISSUED:	7/30/2015
EXPIRES:	7/1/2016

Please contact Amber Dillon for any further questions at 916-574-7938.

Sincerely,

Amber Dillon
Licensing Manager



California State Board of Pharmacy

1625 N. Market Blvd, Suite 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.

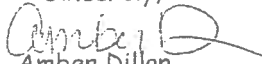
July 30, 2015

RE: LSC 100674
Roxsan Pharmacy, Inc
465 N Roxbury Dr
Beverly Hills, Ca 90210

License LSC 100674 is current and in good standing. No adverse action has been taken against this license. The license information is as follows:

LICENSE:	LSC
LICENSE NO:	100674
ISSUED:	7/30/2015
EXPIRES:	7/1/2016

Please contact Amber Dillon for any further questions at 916-574-7938.

Sincerely,

Amber Dillon
Licensing Manager

Blank