

A

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

\$500.00 Fee made payable to: Nevada State Board of Pharmacy *cashier's check*
(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.

<input checked="" type="checkbox"/> New Pharmacy	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: PH _____)	
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7	<input type="checkbox"/> Partnership - Pages 1,2,5,7
<input 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: AllyScripts

Physical Address: 201 Lonnie E. Crawford Blvd Ste B

Mailing Address: Same as above

City: Scottsboro State: AL Zip Code: 35769

Telephone: (844)309-7171 Fax: (844)309-7173

Toll Free Number: (844)309-7171 (Required per NAC 639.708)

E-mail: info@allyscripts.com Website: allyscripts.com

Managing Pharmacist: Lisa D. Pierce License Number: AL 16643
applying for NV

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 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

B

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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: Alpha-Omega Pharmacy LLC.

Physical Address: 4142 Commercial Way Spring Hill, FL 34606

Mailing Address: 4142 Commercial Way

City: Spring Hill State: Florida Zip Code: 34606

Telephone: 352-600-7950 Fax: 352-600-7955

Toll Free Number: 1-844-557-0835 (Required per NAC 639.708)

E-mail: contact@alpha-omegapharmacy.com Website: www.alpha-omegapharmacy.com

Managing Pharmacist: Don Hanna License Number: PS17531

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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 Non Publicly Traded Corporation – Pages 1,2,4,7 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: DicotrX 1, LLC dba Boerne Drug Company
 Physical Address: 725 N. Main St, Ste 2
 Mailing Address: 725 N. Main St, Ste 2
 City: Boerne State: TX Zip Code: 78004
 Telephone: 830-331-8183 Fax: 830-428-2581
 Toll Free Number: 844-641-7513 (Required per NAC 639.708)
 E-mail: fax@boernedrug.com Website: www.boernedrug.com
 Managing Pharmacist: Tiffany Richard, PIC License Number: 51373 - Tiffany Richard

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 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: _____

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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: BROOKSIDE Pk, LLC

Physical Address: 11020 A STREET

Mailing Address: 11020 A STREET

City: Omaha State: NE Zip Code: 1090137

Telephone: 402-374-4024 Fax: 402-403-4149

Toll Free Number: 977-1647-4455 (Required per NAC 639.708)

E-mail: pharmacist@brooksidepk.com Website: N/A

Managing Pharmacist: Knish Hurley License Number: 123008

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 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: _____

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 Non Publicly Traded Corporation - Pages 1,2,4,7 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: Chemistry Rx Pharmacy

Physical Address: 829 Spruce st Ste 100

Mailing Address: 829 Spruce st Ste 100

City: Philadelphia State: PA Zip Code: 19107

Telephone: 855-790-0100 Fax: 267-861-0862

Toll Free Number: 855-790-0100 (Required per NAC 639.708)

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

Managing Pharmacist: Vicki Jung License Number: RP 44978

TYPE OF PHARMACY AND

SERVICES PROVIDED

- Yes/No
- Retail
 - Hospital (# beds _____)
 - Internet
 - Nuclear
 - Ambulatory Surgery Center
 - Community
 - Other: _____

- 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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 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: HRx Pharmacy LLC

Physical Address: 4227 S Highland Dr. Ste 6

Mailing Address: 4227 S Highland Dr. Ste 6

City: Salt Lake City State: UT Zip Code: 84124

Telephone: 801-553-3426 Fax: 801-553-2540

Toll Free Number: 877-401-4311 (Required per NAC 639.708)

E-mail: cdywalker@gmail.com Website: N/A

Managing Pharmacist: Cody Walker License Number: 6450171-1701

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 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: _____

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2/1/00

G

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(Please provide current license number if making changes: PH _____)	
<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: Incline Health LLC

Physical Address: 331 Tom Hunter Rd, Fort Lee, NJ 07024

Mailing Address: 331 Tom Hunter Rd, Fort Lee, NJ 07024

City: Fort Lee State: New Jersey Zip Code: 07024

Telephone: (201) 676-3838 Fax: (201) 676-3848

Toll Free Number: (844) 294-6402 (Required per NAC 639.708)

E-mail: inclinehealthLLC@gmail.com Website: N/A

Managing Pharmacist: Allison Koch License Number: 28RI03399000

<u>TYPE OF PHARMACY</u>	<u>AND</u>	<u>SERVICES PROVIDED</u>
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 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: _____

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H

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Application type selection box with checkboxes for New Pharmacy, Ownership Change, Publicly Traded Corporation, Non Publicly Traded Corporation, Partnership, and Sole Owner.

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Lumicera Health Services, LLC

Physical Address: 5350 E High Street Suite 200

Mailing Address: 5350 E High Street Suite 200

City: Phoenix State: Arizona Zip Code: 85054

Telephone: 855-847-3553 Fax: 855-547-3558

Toll Free Number: 855-847-3553 (Required per NAC 639.708)

E-mail: contact@lumicera.com Website: www.Lumicera.com

Managing Pharmacist: Peter Nielson License Number: AZ - S017245

TYPE OF PHARMACY AND SERVICES PROVIDED

- Yes/No checkboxes for Retail, Hospital, Internet, Nuclear, Ambulatory Surgery Center, Community, Other: Independent, Off-site Cognitive Services, Parenteral, 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

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I

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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: Medication Review, Inc

Physical Address: 104 S. Freya St, #225 Turquoise Flag Bldg

Mailing Address: 104 S. Freya St, #225 Turquoise Flag Bldg

City: Spokane State: Washington Zip Code: 99202

Telephone: 509-343-5200 Fax: 509-343-5199

Toll Free Number: 800-236-1900 (Required per NAC 639.708)

E-mail: arodriguez@medicationreview.com Website: www.medicationreview.com

Managing Pharmacist: _____ License Number: _____

TYPE OF PHARMACY AND

SERVICES PROVIDED

Yes/No

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

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: Remote order entry

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

AMR

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GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: MEDPHARMA PHARMACY PARTNERS 11, LP dba MEDPHARMA PHARMACY

Physical Address: 2600 N. STEMMONS FWY, STE 164 DALLAS, TEXAS 75207

Mailing Address: 2600 N. STEMMONS FWY, STE 164

City: DALLAS State: TEXAS Zip Code: 75207

Telephone: 469-331-8290 Fax: 469-331-8291

Toll Free Number: 855-550-0976 (Required per NAC 639.708)

E-mail: infoTX@medpharma.com Website: www.medpharma.com

Managing Pharmacist: ANGELA CHI ALVAREZ License Number: 48830

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 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: _____

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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: Medi Script Pharmacy

Physical Address: 8121 Broadway Street Suite #105

Mailing Address: 8121 Broadway Street Suite #105

City: Houston State: TX Zip Code: 77061

Telephone: (713) 910-3774 Fax: (713) 910-3314

Toll Free Number: (877) 578-0906 (Required per NAC 639.708)

E-mail: mediscriptrx@yahoo.com Website: NIA

Managing Pharmacist: Katwala Carole Kalukuta License Number: 50900

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 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 type="checkbox"/> Other Services: _____

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