

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: Option Care
 Physical Address: 2050 S. Finley Rd. Suite 20 Lombard, IL 60148
 Mailing Address: PO BOX 377
 City: Deerfield State: IL Zip Code: 60015
 Telephone: 630-495-2899 Fax: 877-974-4845
 Toll Free Number: 877-974-4844 (Required per NAC 639.708)
 E-mail: oe-providerenrollandlicense@optioncare.com Website: www.optioncare.com
 Managing Pharmacist: Joann Berry-Bedell License Number: 051.038124

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No <input type="checkbox"/> <input checked="" type="checkbox"/> Retail <input type="checkbox"/> <input checked="" type="checkbox"/> Hospital (# beds _____) <input type="checkbox"/> <input checked="" type="checkbox"/> Internet <input type="checkbox"/> <input checked="" type="checkbox"/> Nuclear <input type="checkbox"/> <input checked="" type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> <input checked="" type="checkbox"/> Community <input checked="" type="checkbox"/> <input type="checkbox"/> Other: <u>Closed Door</u>	Yes/No <input type="checkbox"/> <input checked="" type="checkbox"/> Off-site Cognitive Services <input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral ** <input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral (outpatient) <input type="checkbox"/> <input checked="" type="checkbox"/> Outpatient/Discharge <input checked="" type="checkbox"/> <input type="checkbox"/> Mail Service <input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care <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>Infusion Pharmacy</u>
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All boxes must be checked
 For the application to be complete

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

04536

APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

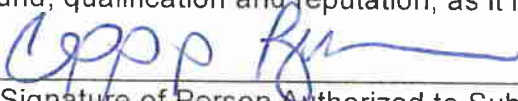
Within the last five (5) years:

- 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

Clifford Berman - Secretary

Print Name of Authorized Person

Date

9/13/16

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: Delaware

Parent Company if any: Walgreens Infusion Services, Inc.

Mailing Address: PO BOX 377

City: Deerfield State: IL Zip: 60015

Telephone: 312-940-2437 Fax: 847-332-0298

Contact Person: Maria Avalos - Licensing Specialist

For any corporation non publicly traded, disclose the following:

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

a) N/A
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

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

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

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

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

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8:30 am 5:30 pm Saturday On Call am On Call pm

Sunday On Call am On Call pm 24 Hours On Call

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

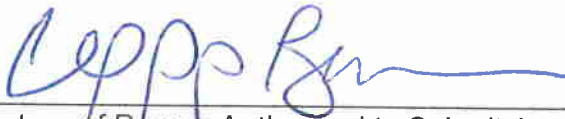
I, Clifford Berman

Responsible Person of Option Care Enterprises, 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

Clifford Berman - Secretary

Print Name of Authorized Person

9/13/16

Date



Illinois Department of Financial and Professional Regulation
Division of Professional Regulation

Bruce Rauner
Governor

Bryan A. Schneider
Secretary

Daniel Kelber
Acting Director
Division of Professional Regulation

CERTIFICATION OF LICENSURE

HI BOARD OF PHARMACY
DCCA-PVL-LICENSING BRANCH
PO BOX 3469
HONOLULU, HI 96801

Licensee: OPTION CARE ENTERPRISES INC
License Number: 054.016748
Profession: LICENSED PHARMACY
Date of Issuance: 10/20/2009
Expiration Date: 03/31/2018
License Status: ACTIVE
License Method: NON-EXAM
Disciplinary History: Has not been disciplined

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.

SEAL

Daniel Kelber
Acting Director
Division of Professional Regulation

August 26, 2016
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

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: 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: eho@paragonhealthcare.com Website: www.paragonspecialty.com

Managing Pharmacist: Eric Dustin Ho License Number: 51668(TX)

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: Hemophilia

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

93711

APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

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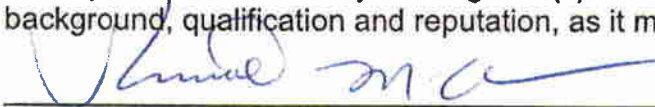
Within the last five (5) years:

- 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

Richard Marvin Allen President, CEO
Print Name of Authorized Person

6/29/16
Date

Page 2

Board Use Only

Date Processed: 8/4/16

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: Paragon Healthcare Inc.
 Mailing Address: 17111 Preston Rd., Ste 100
 City: Dallas State: TX Zip: 75248-1234
 Telephone: 888-588-1072 Fax: 866-388-1488
 Contact Person: Eric Dustin Ho

For any corporation non publicly traded, disclose the following:

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

- a) please see attached sheet
 Name Address
 b) _____
 Name Address
 c) _____
 Name Address
 d) _____
 Name Address

- 2) Provide the number of shares issued by the corporation. 1000
 3) What was the price paid per share? \$ 25,199.00
 4) What date did the corporation actually receive the cash assets? 8/31/11
 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 am 6 pm Saturday on-call 24/7 am _____ pm
 Sunday on-call 24/7 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

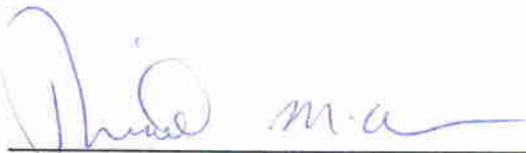
I, Richard Marvin Allen

Responsible Person of Paragon Healthcare Specialty

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

Richard Marvin Allen, President, CEO
Print Name of Authorized Person

6/20/2016
Date

GASTROENTEROLOGY ORDER FORM



****REQUIRED INFORMATION****

- This signed order form from the provider Patient demographics & insurance information
 Clinical/Progress Notes, Labs, Tests supporting primary diagnosis

Patient Name: _____ DOB: _____

Allergies: _____ Patient Phone: _____

Labs: Required labs to be drawn by: Infusion Clinic Referring Physician **Patient weight:** _____ lbs

INFUSION ORDERS

- | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Dehydration _____
<input type="checkbox"/> Gastroenteritis _____
<input type="checkbox"/> Diverticulitis _____

<input type="checkbox"/> Iron Deficiency Anemia

<input type="checkbox"/> Iron Deficiency Anemia with CKD not on dialysis

Required Recent Labs:
HGB, HCT, TIBC, Ferritin

<input type="checkbox"/> Crohn's Disease
ICD-10 Code _____

<input type="checkbox"/> Ulcerative Colitis
ICD-10 Code _____ | <input type="checkbox"/> 1 Liter/ <input type="checkbox"/> 2 Liters D5 .45% NS IV x 1 day
<input type="checkbox"/> 1 Liter/ <input type="checkbox"/> 2 Liters NS IV x 1 day

<input type="checkbox"/> Venofer 200mg IV q 3 weeks x 5 doses
<input type="checkbox"/> Venofer 100 mg IV q week x 7 weeks then every other week x 7 weeks (10 doses total)
<input type="checkbox"/> Venofer 200mg IV - Administer 5 doses over a 14 day period
<input type="checkbox"/> Venofer 200mg IV weekly x 5 weeks
<input type="checkbox"/> Injectafer 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg - <i>if patient weighing less than 50kg (110lbs)</i>
<input type="checkbox"/> Injectafer 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg - <i>if patient weighing 50kg (110lbs) or greater</i>
<input type="checkbox"/> Cimzia 400mg Sub-Q at weeks 0, 2, 4 and then every 4 weeks
<input type="checkbox"/> Cimzia _____ mg Sub-Q every _____ weeks
<input type="checkbox"/> Tysabri 300mg every 4 weeks <input type="checkbox"/> Patient TOUCH authorization
Hepatitis B Protocol: Hep B surface antigen & Hep B Core AB total required.
TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD.
<input type="checkbox"/> Entyvio 300mg IV over 30 minutes at 0, 2, 6 weeks and then Q8weeks
Required Labs: Baseline liver enzymes
TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. | <input type="checkbox"/> Cipro 400mg IV daily x 1 day
<input type="checkbox"/> Flagyl 500mg IV daily x 5 days
<input type="checkbox"/> Invanz 1gm IV daily x 1 day |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
- TB test:** TB Test Attached Perform TB testing

REMICADE INFUSION ORDERS

- Diagnosis:** Crohn's _____ Ulcerative Colitis _____ Other: _____
- Dose:** _____ mg/kg **Frequency:** Every _____ weeks *or* 0, 2, 6 - then every 8 weeks
- Pre-Medication orders:** Tylenol 1000mg
please choose one antihistamine: Cetirizine 10mg PO Diphenhydramine 25mg PO Loratadine 10mg PO
- Additional Pre-Medication Orders:** Solu-Medrol 62.5mg IVP Solu-Medrol 125mg IVP
 Solu-Cortef _____ mg IVP
- TB test:** TB Test Attached Perform TB testing **TB Protocol:** Baseline testing: Quantiferon Gold (QFT Gold) or PPD.
- Hepatitis B Protocol:** Hep B surface antigen and Hep B Core AB total required.
- **Date of last:** Orencia, Remicade, Humira, Enbrel dose: _____

Physician Name: _____ Phone: _____ Fax: _____

****Physician Signature:** _____ **Date:** _____

Please check an Infusion Center Location:

- | | | | | | | |
|------------------------------------|---------------------------------|--------------------------------------|--------------------------------------|------------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> Arlington | <input type="checkbox"/> Dallas | <input type="checkbox"/> North Hills | <input type="checkbox"/> San Antonio | <input type="checkbox"/> Stone Oak | <input type="checkbox"/> Austin | <input type="checkbox"/> Houston |
| P: 817.200.2530 | P: 972.408.2777 | P: 817.284.2700 | P: 210.366.4358 | P: 210.485.3700 | P: 512.261.4800 | P: 713.860.1755 |
| F: 817.509.0011 | F: 469.913.6894 | F: 817.284.2701 | F: 210.366.4896 | F: 210.390.1738 | F: 512.261.4803 | F: 713.277.7219 |

ParagonHealthcare.com