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: oc-providerenrollandlicense@optioncare.com Website: www.optioncare.com

Managing Pharmacist: Joann Berry-Bedell License Number: 051.038124

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☐	☑ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☒	☐ Mail Service
☐	☑ Community	☐	☑ Long Term Care
☒	☐ Other: Closed Door	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
All boxes must be checked		☐	☑ Mail Service Sterile Compounding **
For the application to be complete		☒	☐ Other Services: Infusion Pharmacy

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

94536

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

9/13/16

Date

Board Use Only Date Processed: _____ Amount: $500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY 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

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$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

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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	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☑	☐ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☑	☐ Mail Service
☐	☑ Community	☐	☑ Long Term Care
☐	☑ Other: ____	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
		☐	☑ Mail Service Sterile Compounding **
		☑	☐ Other Services: Hemophilia

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 <u>required</u> to make an appearance at the board meeting,**

93711

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

Richard Marvin Allen President, CEO
Print Name of Authorized Person

6/29/2016
Date

Board Use Only	Date Processed: 8/4/16	Amount: $500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY 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

PARAGON HEALTHCARE INFUSION CENTERS

****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

☐ Dehydration _____
☐ Gastroenteritis _____
☐ Diverticulitis _____

☐ 1 Liter/ ☐ 2 Liters D5 .45% NS IV x 1 day
☐ 1 Liter/ ☐ 2 Liters NS IV x 1 day

☐ **Cipro** 400mg IV daily x 1 day
☐ **Flagyl** 500mg IV daily x 5 days
☐ **Invanz** 1gm IV daily x 1 day

☐ Iron Deficiency Anemia

☐ **Venofer** 200mg IV q 3 weeks x 5 doses
☐ **Venofer** 100 mg IV q week x 7 weeks then every other week x 7 weeks (10 doses total)

☐ Iron Deficiency Anemia with CKD not on dialysis

☐ **Venofer** 200mg IV - Administer 5 doses over a 14 day period
☐ **Venofer** 200mg IV weekly x 5 weeks
☐ **Injectafer** 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg - *if patient weighing less than 50kg (110lbs)*
☐ **Injectafer** 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg - *if patient weighing 50kg (110lbs) or greater*

Required Recent Labs: HGB, HCT, TIBC, Ferritin

☐ Crohn's Disease ICD-10 Code _____

☐ **Cimzia** 400mg Sub-Q at weeks 0, 2, 4 and then every 4 weeks
☐ **Cimzia** _____mg Sub-Q every _____ weeks

☐ Ulcerative Colitis ICD-10 Code _____

☐ **Tysabri** 300mg every 4 weeks ☐ 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.

☐ **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.

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, or ☐ Enbrel dose: _____

Physician Name: _____ **Phone:** _____ **Fax:** _____

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

Please check an Infusion Center Location:

☐ Arlington	☐ Dallas	☐ North Hills	☐ San Antonio	☐ Stone Oak	☐ Austin	☐ 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