

**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**

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

04536

# APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

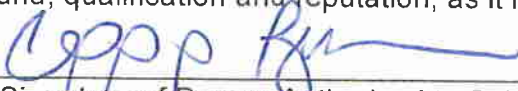
Within the last five (5) years:

- 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

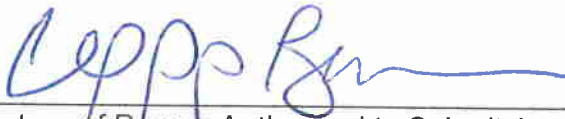
I, Clifford Berman

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 COPY

COPY

\_\_\_\_\_  
 Daniel Kelber  
 Acting Director  
 Division of Professional Regulation

August 26, 2016  
 Date

AK

*Refer to the Department's Web Site at [www.idfpr.com](http://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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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

This page must be submitted for all types of ownership.

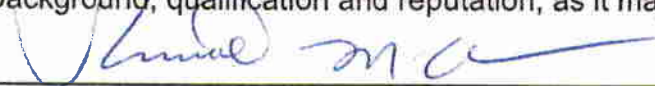
Within the last five (5) years:

- 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

6/29/16  
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

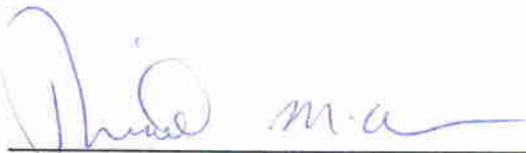
I, Richard Marvin Allen

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 _____<br><input type="checkbox"/> Gastroenteritis _____<br><input type="checkbox"/> Diverticulitis _____<br><br><input type="checkbox"/> Iron Deficiency Anemia<br><br><input type="checkbox"/> Iron Deficiency Anemia with CKD not on dialysis<br><br><b>Required Recent Labs:<br/>HGB, HCT, TIBC, Ferritin</b><br><br><input type="checkbox"/> Crohn's Disease<br>ICD-10 Code _____<br><br><input type="checkbox"/> Ulcerative Colitis<br>ICD-10 Code _____ | <input type="checkbox"/> 1 Liter/ <input type="checkbox"/> 2 Liters D5 .45% NS IV x 1 day<br><input type="checkbox"/> 1 Liter/ <input type="checkbox"/> 2 Liters NS IV x 1 day<br><br><input type="checkbox"/> <b>Venofer</b> 200mg IV q 3 weeks x 5 doses<br><input type="checkbox"/> <b>Venofer</b> 100 mg IV q week x 7 weeks then every other week x 7 weeks (10 doses total)<br><input type="checkbox"/> <b>Venofer</b> 200mg IV - Administer 5 doses over a 14 day period<br><input type="checkbox"/> <b>Venofer</b> 200mg IV weekly x 5 weeks<br><input type="checkbox"/> <b>Injectafer</b> 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg - <i>if patient weighing less than 50kg (110lbs)</i><br><input type="checkbox"/> <b>Injectafer</b> 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg - <i>if patient weighing 50kg (110lbs) or greater</i><br><input type="checkbox"/> <b>Cimzia</b> 400mg Sub-Q at weeks 0, 2, 4 and then every 4 weeks<br><input type="checkbox"/> <b>Cimzia</b> _____ mg Sub-Q every _____ weeks<br><input type="checkbox"/> <b>Tysabri</b> 300mg every 4 weeks <input type="checkbox"/> Patient TOUCH authorization<br><b>Hepatitis B Protocol:</b> Hep B surface antigen & Hep B Core AB total required.<br><b>TB Protocol:</b> Baseline testing: Quantiferon Gold (QFT Gold) or PPD.<br><input type="checkbox"/> <b>Entyvio</b> 300mg IV over 30 minutes at 0, 2, 6 weeks and then Q8weeks<br><b>Required Labs:</b> Baseline liver enzymes<br><b>TB Protocol:</b> Baseline testing: Quantiferon Gold (QFT Gold) or PPD. | <input type="checkbox"/> <b>Cipro</b> 400mg IV daily x 1 day<br><input type="checkbox"/> <b>Flagyl</b> 500mg IV daily x 5 days<br><input type="checkbox"/> <b>Invanz</b> 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, or     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