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12A

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: AZBDBR, LLC dba AvasaRx Pharmacy

Physical Address: 816 N. 6th Ave.

Mailing Address: 816 N. 6th Ave.

City: Phoenix State: AZ Zip Code: 85003

Telephone: 480-900-7450 Fax: 833 437-2301

Toll Free Number: 844-482-2005 (Required per NAC 639.708)

E-mail: info@avasarx.com Website: AVASARX.COM

Managing Pharmacist: Ronak Modi License Number: S023110

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: Independent	☐ ☑	Sterile Compounding **
		☐ ☑	Non Sterile Compounding
	All boxes must be checked	☐ ☑	Mail Service Sterile Compounding **
	For the application to be complete	☑ ☐	Other Services: Home Infusion

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

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

CHAITANYA GADDE
Print Name of Authorized Person

11/1/2018
Date

Board Use Only Date Processed: _____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP

General _____ Limited L

Partnership Name: AZBDBR, LLC

Mailing Address: 816 N. 6th Ave.

City: Phoenix State: AZ Zip Code: 85003

Telephone Number: 480-900-7450 Fax Number: 833-437-2301

Contact Person: Ronak Modi

List each partner and identify whether (G)eneral or (L)imited partner and percentage of ownership
Use separate sheet if necessary

Name	G or L	Percentage
Arizona Hemophilia Association	L	51%
Bio Tek reMEDys, Inc.	L	49%

List names of 4 largest partners and percentage of ownership:

Name: Arizona Hemophilia Association %: 51%

Name: Bio Tek reMEDys, Inc. %: 49%

Name: _____ %: _____

Name: _____ %: _____

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9:00 am 5:00 pm MST Saturday x am x pm

Sunday x am x 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: _____

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, CHAITANYA GADDE

Responsible Person of AZBDBR, LLC dba AvasaRx 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

CHAITANYA GADDE
Print Name of Authorized Person

11/1/2018
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF DELAWARE)
) ss.
NEW CASTLE COUNTY)

I, Chaitanya Gadde, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the Authorized Signer for AZBDBR, LLC dba Avasa Rx (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out-of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, Chaitanya Gadde, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
1st day of November, 2018.

NOTARY PUBLIC

REETA SHARMA
MY COMMISSION
EXPIRES ON
09-25-2020
NOTARY PUBLIC
STATE OF DELAWARE

OWNERS

- AZ Hemophilia Assoc. 826 N. 5th Ave, Phoenix, AZ 85003 602-955-3947
- Bio Tek reMEDys, Inc. 2 Penns Way, Suite #404, New Castle, DE 19720 302-544-5138

	Pharmacist	License #
• Ronak Modi	W. Portland Street, Phoenix, AZ 85003	S023110

	Pharmacy Technician	License #
• Shelomith Adina David	) N. 47th Dr., Phoenix, AZ 85031	10049494

AvasaRX
816 N. 6th Ave. Phoenix, AZ 85003
Tel: 844-482-2005
Fax: 833-437-2301
www.avasarx.com

ARIZONA STATE BOARD OF PHARMACY
P.O. Box 18520 Phoenix, AZ 85005
602-771-ASBP (2727)
FAX: 602-771-2749
http://www.azpharmacy.gov

Receipt Date: 10/02/2018
Receipt Number: 201843721
Receipt Amount $: 240.00

Resident Pharmacy/Limited Service

Retail

	PERMIT NO	EXPIRES
	Y007409	10/31/2019
Issued to :	AZBDBR, LLC 816 N. 6TH AVE. PHOENIX, AZ 85003	AvasaRx Pharmacy 816 N 6TH AVENUE PHOENIX, AZ 85003

Kam Gandhi
EXECUTIVE DIRECTOR

ARIZONA STATE BOARD OF PHARMACY
P.O. Box 18520
Phoenix, AZ 85005
602-771-ASBP (2727)
FAX: 602-771-2749

WALLET CARD

NAME : AZBDBR, LLC
LICENSE NUMBER : Y007409
EXPIRES : 10/31/2019

http://www.azpharmacy.gov

- Your license must be available for inspections during business hours.
- Permit holder(s) must display permit in the location to which it is issued.
- Please note it is your responsibility to keep this license/permit current.

Important Information

LICENSE HOLDER (pharmacist, intern, technician, technician-trainee)

Holder of this license number, printed above, is authorized in accordance with A.A.C. R4-23-201(A), A.A.C. R4-23-301(A) or A.A.C R4-23-1101(A), to perform the duties associated within their profession. By holding this license, the licensee agrees to comply with state & federal law.
You are required by law to notify the Board of any home address and/or employment change within 10 business days

PERMIT HOLDER (pharmacy, non-prescription retailer (OTC), wholesale, manufacture, CMG, DME)

Holder of this permit number, printed above, is authorized to conduct business according to the classification specified in A.R.S. § 32-1908(A); A.A.C. R4-23-601 and A.A.C. R4-23-607. By holding this permit, the permittee agrees to comply with state & federal law
In-state pharmacy, wholesaler & manufacture permit holder(s) who plan to remodel or move locations, must submit a change-of-location/remodel form within 30 days prior to move/remodel. In-state non-prescription (OTC), compressed medical gas (CMG) & DME providers who plan to move locations must notify the board within 10 business days of move.
Out-of-State permit holders must notify the Board of location changes, in writing, within 10 business days of move. A revised copy of your state permit shall be submitted to the Board, when available.
Permits are non-transferable. Ownership changes of more than 30% require that a new application be submitted to the Board.

12B

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**)

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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: Premier Specialty Infusion, LLC

Physical Address: 2401 Hassell Rd Ste 1525

Mailing Address: 2401 Hassell Rd. Ste 1525

City: Hoffman Estates State: ILLINOIS Zip Code: 60169

Telephone: 800-783-9655 Fax: 877-770-4179

Toll Free Number: 800-783-9655 (Required per NAC 639.708)

E-mail: scott.luckow@psinfusion.com Website: www.psinfusion.com

Managing Pharmacist: Scott Luckow License Number: 51.041005

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
	All boxes must be checked	☐	☒ Mail Service Sterile Compounding **
	For the application to be complete	☐	☒ 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,**

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.

Scott

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

Scott Luckow

Print Name of Authorized Person

10/23/18

Date

Board Use Only	Date Processed:	Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP General ____ Limited ✓

Partnership Name: Premier Specialty Infusion LLC

Mailing Address: 2401 Hassell Rd Ste 1525

City: Hoffman Estates State: IL Zip Code: 60169

Telephone Number: 800·783·9655 Fax Number: 877-770-4179

Contact Person: Scott Luckow

List each partner and identify whether (G)eneral or (L)imited partner and percentage of ownership
Use separate sheet if necessary

Name	G or (L)	Percentage
Ambreen Vafri	L	97%
Scott Luckow	L	3%

List names of 4 largest partners and percentage of ownership:

Name: N/A %: ____

Name: ____ %: ____

Name: ____ %: ____

Name: ____ %: ____

List any physician shareholders and percentage of ownership.

Name: N/A %: ____

Name: ____ %: ____

Name: ____ %: ____

Hours of Operation for the pharmacy:

Monday thru Friday 8:00 am 5:00 pm Saturday 24 am 7 pm

Sunday 24 am 7 by phone pm 24 Hours ____ by phone

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: N/A

Business Name: _____

Current Business Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday N/A am _____ pm Saturday N/A am _____ pm

Sunday N/A 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, Scott Luckow

Responsible Person of Premier Specialty Infusion LLC

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.

Scott

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

Scott Luckow

Print Name of Authorized Person

10/23/18

Date

Include with the Application for Authority to Dispense Drugs

Practitioner Dispensing
Controlled Substance Waiver Form

Each dispensing practitioner must complete this form. Do not submit for a group.

Print Name: Premier Specialty Infusion, LLC

Address: 2401 Hassell Rd Ste. 1525

City: Hoffman Estates State: IL Zip: 60169

Telephone: 800-783-9655

_____ I will be dispensing controlled substances at the address listed above and I understand that I am required and submit data to the Prescription Controlled Substance Abuse Prevention Task Force weekly as required by NAC 639.745 [1(f)].

__X__ I will not be dispensing controlled substances at the address listed above. If I choose to dispense controlled substances in the future, I must contact the Nevada State Board of Pharmacy to modify my license.

By signing and dating this waiver form, I certify that the information provided is true.

Original Signature of Dispensing Practitioner

10/23/18
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF ILLINOIS)
) ss.
KANE COUNTY)

AILEEN M WARREN
Official Seal
Notary Public – State of Illinois
My Commission Expires Jan 25, 2021

I, Scott Luckow, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the Pharmacist In Charge for Premier Specialty Infusion (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out-of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, Scott Luckow, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Scott
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
23 day of October, 2018.

Aileen M Warren
NOTARY PUBLIC

AILEEN M WARREN
Official Seal
Notary Public – State of Illinois
My Commission Expires Jan 25, 2021

Premier
SPECIALTY INFUSION

To Whom It May Concern:

Below is a list containing the Name, Date of Birth, and Address of All Corporate Officers, Partners or Owner(s):

Scott Luckow

Pharmacy Manager, PIC, Owner

W437 Bode Rd

Elgin, IL 60120

DOB: 5

Ambreen Jafri

Pharmacy Owner, Partner

' Lake Adalyn Drive

South Barrington, IL 60010

DOB:

Thank you,

Premier Specialty Infusion

2401 W Hassell Rd, Suite 1525

Hoffman Estate, IL 60169

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "PREMIER SPECIALTY INFUSION, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE SEVENTEENTH DAY OF OCTOBER, A.D. 2018.

Jeffrey W. Bullock, Secretary of State

6225542 8300

SR# 20187166020

Authentication: 203631232

Date: 10-17-18

You may verify this certificate online at corp.delaware.gov/authver.shtml

File Number 0616916-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

PREMIER SPECIALTY INFUSION, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MARCH 06, 2017, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 8TH *day of* NOVEMBER *A.D.* 2018 .

Jesse White

SECRETARY OF STATE

Authentication #: 1831202040 verifiable until 11/08/2019

Authenticate at: http://www.cyberdriveillinois.com

Premier
SPECIALTY INFUSION

COPY

Sent to:
DFPR
10.17.18
copy of check attached

October 16, 2018

To Whom It May Concern,

We are pursuing an out of state pharmacy license and need to request an **Illinois Certification of Licensure** for our Pharmacy.

Premier Specialty Infusion LLC
2401 Hassell Rd. Ste 1525
Hoffman Estates, IL 60169

License#: 054.020273 - Active
Issued: 04/20/2017
Expires: 03/31/2020
Method of Licensure: Paper
Disciplinary Action: N

Please send the above Illinois Certification of Licensure to:

Nevada State Board of Pharmacy
431 W Plum Lane
Reno, NV 89509

Thank you,

Aileen Warren, PharmD, RPh
Director Of Operations
Aileen.warren@psinfusion.com
800-783-9655

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO.
054.020273
051.041005

The person, firm, or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below:

EXPIRES:
03/31/2020

LICENSED PHARMACY

COMMUNITY

PREMIER SPECIALTY INFUSION LLC
SCOTT LUCKOW
2401 HASSELL RD STE 1525
HOFFMAN ESTATES, IL 60169-2000

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

12389962

Cut on Dotted Line

For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 4052203

12C

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

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

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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: Soleo Health Inc.

Physical Address: 10210 Werch Drive, Suite 202

Mailing Address: Same

City: Woodridge State: IL Zip Code: 60517-4809

Telephone: (630) 589-8054 Fax: (877) 393-1616

Toll Free Number: (844) 575-1515 (Required per NAC 639.708)

E-mail: licensure@soleohealth.com Website: www.soleohealth.com

Managing Pharmacist: Jason Howard, PharmD License Number: 051.293255

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: Specialty	☐	☒ Sterile Compounding **
		☐	☒ Non Sterile Compounding
	All boxes must be checked	☐	☒ Mail Service Sterile Compounding **
	For the application to be complete	☒	☐ Other Services: IVIG, Factor

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

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 ☒

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

John Ginzler
Print Name of Authorized Person

January 30, 2019
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: NA

Mailing Address: 11 Trafalgar Square, Suite 101

City: Nashua State: NH Zip: 03063-1991

Telephone: (833) 765-3648 Fax: (603) 718-3824

Contact Person: Christine Belanger

For any corporation non publicly traded, disclose the following:

***No persons

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

a) Soleo Health Holdings, Inc. 100%
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. 100

3) What was the price paid per share? $0.01/share par value

4) What date did the corporation actually receive the cash assets? 2/14/2014

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 8:00 am 5:00 pm Saturday On call am _____ pm

Sunday On call am _____ pm 24 Hours 24/7

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, John Ginzler

Responsible Person of Soleo Health 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

John Ginzler
Print Name of Authorized Person

January 30, 2019
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF New Hampshire)
) ss.
Hillsborough COUNTY)

I, John Ginzler, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the Chief Financial Officer for Soleo Health Inc. (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out-of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, John Ginzler, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
30th day of January, 2019.

NOTARY PUBLIC

CHRISTINE H. BELANGER
NOTARY PUBLIC
STATE OF NEW HAMPSHIRE
- MY COMMISSION EXPIRES JULY 27, 2023 -

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "SOLEO HEALTH INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE THIRTEENTH DAY OF APRIL, A.D. 2018.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "SOLEO HEALTH INC." WAS INCORPORATED ON THE TWENTY-FOURTH DAY OF FEBRUARY, A.D. 2014.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

Jeffrey W. Bullock, Secretary of State

5486590 8300

SR# 20182683263

Authentication: 202511191

Date: 04-13-18

You may verify this certificate online at corp.delaware.gov/authver.shtml

Illinois Department of Financial and Professional Regulation

Lookup Detail View

Contact

Contact Information

Name	City/State/Zip	DBA
SOLEO HEALTH INC	Woodridge, IL 60517	

License

License Information

License Number	Description	Status	First Effective Date	Effective Date	Expiration Date	Ever Disciplined
054020894	LICENSED PHARMACY	ACTIVE	11/14/2018	11/14/2018	03/31/2020	N

Generated on: 1/29/2019 12:37:22 PM

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO.
054.020894
051.293255

The person, firm, or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below:

EXPIRES:
03/31/2020

LICENSED PHARMACY

COMMUNITY

SOLEO HEALTH INC
JASON HOWARD
10210 WERCH DR STE 202
WOODRIDGE, IL 60517-4814

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

13436503

Cut on Dotted Line

For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 4169695

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO.
051.293255

The person, firm, or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below:

EXPIRES:
03/31/2020

REGISTERED PHARMACIST

JASON R HOWARD
14620 MEADOW LN
PLAINFIELD, IL 60544

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

12647072

Cut on Dotted Line

For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 375123

LICENSE NO.
051.293255

Department of Financial and Professional Regulation
Division of Professional Regulation

REGISTERED PHARMACIST

JASON R HOWARD

EXPIRES:
03/31/2020

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

Cut on Dotted Line

Soleo Health

Sharon Hill, PA

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Home Care Accreditation Program

August 25, 2018

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #574329
Print/Reprint Date: 10/19/2018

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.