

**14**

**14A**

# 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 02851**)  
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: MILLER'S OF WYCKOFF

Physical Address: 678 WYCKOFF AVE

Mailing Address: \_\_\_\_\_

City: WYCKOFF State: NJ Zip Code: 07481

Telephone: 201-891-3333 Fax: 201-891-6392

Toll Free Number: 888-891-3334 (Required per NAC 639.708)

E-mail: PROUGH@YOURLIKOR.COM Website: YOURLIKOR.COM  
MILLERS PHARMACY.COM

Managing Pharmacist: DAVID M. MILLOR License Number: (NJ) 28RT01608500

### TYPE OF PHARMACY AND

### SERVICES PROVIDED

Yes/No

- ☒ ☐ Retail  
☐ ☒ Hospital (# beds \_\_\_\_\_)  
☐ ☒ Internet  
☐ ☒ Nuclear  
☐ ☒ Ambulatory Surgery Center  
☒ ☐ Community  
☒ ☐ Other: COMPOUNDING

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: \_\_\_\_\_

**\*\*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.

Philip J. Kroun IV  
Original Signature of Person Authorized to Submit Application, no copies or stamps

PHILIP J. KROUN IV  
Print Name of Authorized Person

11-23-18  
Date

Page 2

Board Use Only

Date Processed: \_\_\_\_\_

Amount: 500.00



**Must be included with the application for a non publicly traded corporation**

Certificate of Corporate Status (also referred to as Certificate of Good Standing). The Certificate is obtained from the Secretary of State's office in the State where incorporated. The Certificate of Corporate status must be dated within the last 6 months.

List of officers and directors

SEE ATTACHMENT

STATEMENT OF RESPONSIBILITY  
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, PHILIP J. KEOUGH IV  
Responsible Person of YOUR LIBRARY, INC DBA MILLERS OK MYCHARD  
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.

Philip J. Keough IV  
Original Signature of Person Authorized to Submit Application, no copies or stamps

PHILIP J. KEOUGH IV  
Print Name of Authorized Person

12-4-18  
Date

# AFFIDAVIT for Out-of-State Pharmacy License

STATE OF \_\_\_\_\_ )  
 ) ss.  
 \_\_\_\_\_ COUNTY )

I, PHIL KEOLAH, 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 CEO/PRESIDENT for MILLERS OR MYCKORP (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, PHIL KEOLAH, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

*Philip Keolah*  
 Name

SUBSCRIBED AND SWORN TO  
 before me, a notary public this  
4 day of DECEMBER 2018.

*Renata M. Weiss*  
 NOTARY PUBLIC





NEVADA STATE BOARD OF PHARMACY

(Licensee mailing address for window envelope)

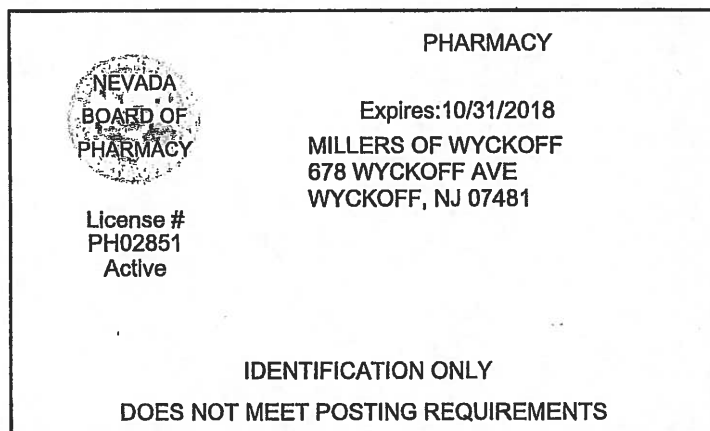
THIS STUB IS YOUR RECEIPT

Date: 11/04/2016  
Amount: 500.00  
License #: PH02851

MILLERS OF WYCKOFF  
678 WYCKOFF AVE  
WYCKOFF, NJ 07481

(ID Card)

Trim ID Card to fit your wallet



**STATE OF NEVADA  
STATE BOARD OF PHARMACY**



License Type: PHARMACY

License #: PH02851

DEA #: BM4899615

THE UNDER-NOTED HAVING PAID STATUTORY FEE IS HEREBY LICENCED

Expires: 10/31/2018  
STATUS: Active

MILLERS OF WYCKOFF  
678 WYCKOFF AVE  
WYCKOFF, NJ 07481

**NONTRANSFERABLE**  
POST THIS LICENSE PROMINENTLY IN A CONSPICUOUS PLACE

State Of New Jersey  
New Jersey Office of the Attorney General  
Division of Consumer Affairs

THIS IS TO CERTIFY THAT THE  
Board of Pharmacy

HAS LICENSED

MILLERS OF WYCKOFF INC  
DAVID M MILLER  
678 WYCKOFF AVE  
WYCKOFF NJ 07481-1430

FOR PRACTICE IN NEW JERSEY AS A(N): Pharmacy

06/06/2018 TO 06/30/2019  
VALID

  
Signature of Licensee/Registrant/Certificate Holder

28RS00529600  
LICENSE/REGISTRATION/CERTIFICATION #

  
ACTING DIRECTOR



# NEW JERSEY DIVISION OF CONSUMER AFFAIRS

**Paul R. Rodrí**  
Acting Dir  
Rea.

## License Information

Accurate as of November 23, 2018 12:13 PM

[Return to Search Results](#)

**Name:** MILLERS OF WYCKOFF INC

**Address:** WYCKOFF,NJ

**Profession/License Type:** Pharmacy,Pharmacy

**License No:** 28RS00529600

**License Status:** Active

**Status Change Reason:**

**Issue Date:** 4/10/1996

**Expiration Date:** 6/30/2019

**Board Action:** YES\*

Please visit DCA's website to see the final disposition documents.

\* A "YES" in the "Board Action" field indicates that the licensee has a public record of some form of action on file with the Board/Committee. Board actions may come in the form of a Cease and Desist Order, Interim Order, Reprimand, a finalized Uniform Penalty Letter, agreed upon Settlement Letter or Final Order. In some instances, "Yes" will represent that a public record such as an Administrative Complaint or a Provisional Order of Discipline may have been filed with the Board/Committee. Such documents represent the filing of allegations by the Attorney General's Office. They do not represent a finding of misconduct until the matter is adjudicated by the Board. Contact the Board/Committee directly to obtain a copy of such documents.

### Division

Division Home  
Consumer Protection  
Licensing Boards  
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Adoptions & Rule  
Proposals  
Internship  
Opportunities

### Department

OAG Home  
Contact OAG  
FAQ OAG  
OAG News  
Services A to Z  
Employment

### State

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Services A-Z  
Departments/Agencies  
FAQs

### Legal

Legal Statement  
Privacy Notice  
Accessibility  
Statement



### RSS

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**STATE OF NEW JERSEY  
DEPARTMENT OF THE TREASURY  
DIVISION OF REVENUE AND ENTERPRISE SERVICES  
SHORT FORM STANDING**

**MILLERS OF WYCKOFF, INC.  
6085010000**

*I, the Treasurer of the State of New Jersey, do hereby certify that the above-named New Jersey Domestic For-Profit Corporation was registered by this office on January 02, 1957.*

*As of the date of this certificate, said business continues as an active business in good standing in the State of New Jersey, and its Annual Reports are current.*

*I further certify that the registered agent and office are:*

DAVID MILLER  
678 WYCKOFF AVE  
WYCKOFF, NJ 07481



*IN TESTIMONY WHEREOF, I have  
hereunto set my hand and affixed  
my Official Seal at Trenton, this  
13th day of September, 2018*

Elizabeth Maher Muoio  
State Treasurer

Certificate Number : 6091219667

Verify this certificate online at

[https://www1.state.nj.us/TYTR\\_StandingCert/JSP/Verify\\_Cert.jsp](https://www1.state.nj.us/TYTR_StandingCert/JSP/Verify_Cert.jsp)

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
BM4899615	01-31-2020	\$731
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	RETAIL PHARMACY-COLLECTOR	12-05-2016
MILLERS OF WYCKOFF INC 678 WYCKOFF AVE WYCKOFF, NJ 07481-0000		

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE  
UNITED STATES DEPARTMENT OF JUSTICE  
DRUG ENFORCEMENT ADMINISTRATION  
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 858) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE  
UNITED STATES DEPARTMENT OF JUSTICE  
DRUG ENFORCEMENT ADMINISTRATION  
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
BM4899615	01-31-2020	\$731
SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	RETAIL PHARMACY-COLLECTOR	12-05-2016
MILLERS OF WYCKOFF INC 678 WYCKOFF AVE WYCKOFF, NJ 07481-0000		

m DEA-223 (9/2016)

Sections 304 and 1008 (21 USC 824 and 858) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

# Delaware

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The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF  
DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT  
COPY OF THE CERTIFICATE OF INCORPORATION OF "YOURLIFERX, INC.",  
FILED IN THIS OFFICE ON THE TWENTIETH DAY OF DECEMBER, A.D.  
2017, AT 12:40 O'CLOCK P.M.

A FILED COPY OF THIS CERTIFICATE HAS BEEN FORWARDED TO THE  
NEW CASTLE COUNTY RECORDER OF DEEDS.



6671413 8100  
SR# 20177685999

You may verify this certificate online at [corp.delaware.gov/authver.shtml](http://corp.delaware.gov/authver.shtml)

A handwritten signature in black ink, appearing to read "JB", is written over a horizontal line. Below the line, the text "Jeffrey W. Bullock, Secretary of State" is printed.

Jeffrey W. Bullock, Secretary of State

Authentication: 203800773  
Date: 12-20-17



PHILIP D. MURPHY  
Governor

SHEILA Y. OLIVER  
Lt. Governor

## New Jersey Office of the Attorney General

Division of Consumer Affairs  
Board of Pharmacy  
124 Halsey Street, 6<sup>th</sup> Floor, Newark NJ 07102



GURBIR S. GREWAL  
Attorney General

PAUL R. RODRIGUEZ  
Acting Director

Mailing Address:  
P.O. Box 46018  
Newark, NJ 07101  
(973) 604-6450

**CERTIFIED MAIL  
RETURN RECEIPT REQUESTED**

August 30, 2018

David Miller, RPIC  
Millers of Wyckoff Pharmacy  
678 Wyckoff Avenue  
Wyckoff, New Jersey 07481

Re: Inspection #8-2498-17-160  
Date of Inspection: 3/1/17


Dear Mr. Miller:

After affording you an opportunity to discuss the above-referenced matter with the New Jersey State Board of Pharmacy on August 22, 2018, the Board has decided to remove citation N.J.A.C.13:39-11.16(a) and mitigate citation N.J.A.C.13:39-11.24(a)10 to a Warning.

Please complete the attached **Certification** form and submit \$1,000.00 for fines incurred to the Board within 15 days receipt of this letter.

**NEW JERSEY STATE BOARD OF PHARMACY**

By:

  
Anthony Rubinaccio, RPh  
Executive Director

AR/rh  
(8/17)

# CERTIFICATION

I, DAVID MILLER, hereby acknowledge that I have read and reviewed the Board's letter dated August 30, 2018 regarding allegations of violations of the Board's enabling act and/or regulations.


Please Check One:

☒ I acknowledge the conduct which has been charged and agree to:

**Cease and desist from engaging in the conduct alleged and pay a penalty in the amount of \$1,000.00 (to be paid upon signing of this Certification).**

I am also aware that the action taken against me by the Board herein is a matter of public record, and that the Board's letter and this Certification are public documents.

Dated: 9/4/18

  
(Signature)  
DAVID MILLER  
(Print Name)

Ref: David Miller, RPIC  
Millers of Wyckoff Pharmacy  
678 Wyckoff Avenue  
Wyckoff, NJ 07481  
(28RS00529600)  
Inspection #8-2498-17-160

AR/rh  
(8/17)



## ATTACHMENT A

Millers of Wyckoff Pharmacy – 678 Wyckoff Avenue, Wyckoff, New Jersey 07481  
 Pharmacist-In-Charge: David Miller  
 Bureau File #8-2498-17-160, Period: 3/1/17  
 Reference: Board of Pharmacy inspection conducted per N.J.S.A.45:1-18 and N.J.S.A.45:14-48(a)11&12, and a memorandum, dated February 6, 2017 from Anthony Rubinaccio, Executive Director, Board of Pharmacy, to Edward Tumminello, Chief, Enforcement Bureau, requesting an inspection for the subject pharmacy in connection with an application for a Remodeling.

## Details

CITE	DESCRIPTION	FINE
N.J.A.C.13:39-11.24(a)10	When test result indicated that the cleanroom did not meet the standards established, the pharmacy failed to immediately cease using the cleanroom that was out of compliance until such time that the cleanroom met the requisite standards.	Warning
N.J.A.C.13:39-11A.9(g)	During the compounding of hormonal products, the pharmacy failed to adhere to standards establish by the Occupational Safety and Health Administration (OSHA):  Specifically, most commonly compounded non-sterile preparation are hormonal related products, in the dosage forms of capsules, creams and ointments. Hazardous Active Pharmaceutical Ingredients (API), such as Progesterone and Testosterone, as well as batch prepared hormonal products, were observed to be stored in the active inventory along with non-hazardous API's.	\$1,000.00
<b>TOTAL: \$1,000.00</b>		

**14B**

# 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 03149**)  
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: OSRX, Inc.

Physical Address: 1120 Kensington Ave. Ste. E

Mailing Address: 1120 Kensington Ave. Ste. E

City: Missoula State: MT Zip Code: 59801

Telephone: 406-541-6121 Fax: 406-541-6267

Toll Free Number: 1-855-466-1076 (Required per NAC 639.708)

E-mail: info@osrxpharmaceuticals.com

Website: www.osrxpharmaceuticals.com

Managing Pharmacist: Amy Frost License Number: MT 5245

### 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:

**\*\*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.

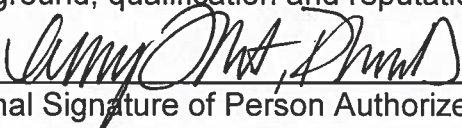
Within the last five (5) years:

- 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.

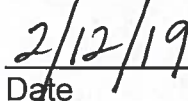
I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to 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



Print Name of Authorized Person



Date

Page 2

Board Use Only

Date Processed: \_\_\_\_\_

Amount: \_\_\_\_\_



## APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

**OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION**State of Incorporation: DelewareParent Company if any: n/aMailing Address: 1120 Kensington Ave. Ste. ECity: Missoula State: MT Zip: 59801Telephone: 406-541-6121Fax: 406-541-6267Contact Person: Amy Frost

For any corporation non publicly traded, disclose the following:

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

a) Anthony Sampietro 634 4th st Hermosa Beach, CA 90254

Name Address

b) Amy Frost 504 Roman Dr. Stevensville, MT 59870

Name Address

c) \_\_\_\_\_  
Name Addressd) \_\_\_\_\_  
Name Address2) Provide the number of shares issued by the corporation. 80,0003) What was the price paid per share? \$0.00014) What date did the corporation actually receive the cash assets? 11/5/18

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:** Pharmacist on call after hours w/ access toMonday thru Friday 9 am 5 pm Patient Records Saturday closed am \_\_\_\_\_ pmSunday closed am \_\_\_\_\_ pm 24 Hours \_\_\_\_\_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, Amy Frost, PharmD  
Responsible Person of DSRX

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.

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

Amy Frost, PharmD  
Print Name of Authorized Person

2/15/19  
Date

## OSRX, Inc. Ownership Structure

### OSRX, Inc.

1120 Kensington Avenue Suite E

Missoula, MT 59801

FEIN 83-0669663

Effective Date of ownership change 4/01/2019

Date of incorporation in DE 04/27/2018 File # 6862461

info@osrxpharmaceuticals.com

Ph: 406-541-6121

Fax: 406-541-6267

### Owner / President

Anthony Sampietro 60%

1 4<sup>th</sup> Street

Hermosa Beach, CA 90254

DOB

SS

Phone

### Owner / Vice President

Amy Frost PharmD 40%

4 Roman Drive

Stevensville, MT 59870

DOB

SS

Phone

## Description of Operations

OSRX, Inc. is a compounding pharmacy providing compounded sterile and non- sterile preparations after receipt of a patient specific prescription.

OSRX, Inc. specializes in compounding and provides the highest level of quality to our patients. All staff are trained and evaluated for competency in relation to assigned duties and documented according to standard operating procedures. All pharmacists have attended accredited training courses in compounding and maintain a complimentary portfolio of applied continuing education.

All raw materials are purchased through accredited wholesalers only and certificate of analysis are available for inspection and review. USP Guidelines are adhered to with quality control testing provided for formulations. We utilize a third party analytical testing company to perform sterility, endotoxin, potency and other testing procedures as necessary. We have been inspected by VPP and are ACHC/PCAB accredited.

Our quality control team includes two Microbiologists and two PharmD's who review operations on a weekly basis including environmental monitoring, preparation test results, lab scheduling, training and competency evaluations, reported adverse events, vendor reports, certification scheduling and additional topics to maintain industry best practice and ensure the safety of our patients.

With each new patient prescription that is received via fax or phone, a telephone call will be made to the patient to establish contact and initiate a relationship. Upon shipping through USPS or FedEx, the medication/information sheet will be included with each package and will include the toll free contact number and hours of operation. All refills will include pertinent medication education guides and contact information for questions. We provide an after-hours call service and patients or prescribers can be directed to a pharmacist in the event of an emergency. The pharmacist has access to patient's records in this circumstance.

In the rare event a patients' insurance is billed all applicable co-pays are collected. The majority of our business is direct patient pay and invoices are handled accordingly.



Currently:  
Pinnacle Compounding  
1120 Kensington Ave Ste E  
Missoula, MT 59801

After Merger  
OSRX, Inc.  
1120 Kensington Ave Ste E  
Missoula, MT 59801

May 16, 2019

Nevada Board of Pharmacy  
431 Plumb Lane  
Reno, NV 89509

To Whom It May Concern;

We are in the process of completing transition of ownership via Merger from Pinnacle Compounding to OSRX, Inc. I understand that the state of Nevada requires an in-person appearance for all sterile compounders. The merger will not affect or change any of the current operations, staff or preparations. I, Amy Frost, interviewed with the board in Las Vegas on July 20, 2017 and was awarded a non-resident permit that remains active and in good standing. All states currently held (45) have remained in good standing and all inspections have demonstrated or exceeded compliance with USP <797>.

Under the circumstances does the board require and secondary interview?

Please feel free to contact me if you have any questions.

Sincerely,



Amy Frost, PharmD

SEE RESTRICTIVE LEGENDS ON REVERSE SIDE OF CERTIFICATE

C-1 Incorporated Under  
the Laws of the State of Delaware  
\*\*48,000\*\*

**OSRX, INC.**

Common Stock

*THIS CERTIFIES THAT Anthony Sampietro is the record holder of 48,000 Shares of the Common Stock of OSRX, Inc., a Delaware corporation (the "Corporation"), transferable only on the books of the Corporation by the holder hereof, in person or by duly authorized attorney, upon surrender of this Certificate properly endorsed or assigned.*

*A statement of the rights, preferences, privileges and restrictions granted to or imposed upon the respective classes or series of shares of stock of the Corporation and upon holders thereof as established by the Certificate of Incorporation or by any Certificate of Designation of Preferences, and the number of shares constituting each series and the designations thereof, may be obtained by any shareholder upon request and without charge at the principal office of the Corporation.*

*IN WITNESS WHEREOF, the Corporation has caused this Certificate to be signed by its duly authorized officers on November 5, 2018.*

DocuSigned by:  
*Anthony Sampietro*  
2471000AD181476  
Anthony Sampietro, President

DocuSigned by:  
*Amy Frost*  
4b4c93741853940b  
Amy Frost, Vice President and Secretary

SEE RESTRICTIVE LEGENDS ON REVERSE SIDE OF CERTIFICATE

C-2 Incorporated Under  
the Laws of the State of Delaware \*\*32,000\*\*

## OSRX, INC.

### Common Stock

*THIS CERTIFIES THAT Anthony Sampietro is the record holder of 32,000 Shares of the Common Stock of OSRX, Inc., a Delaware corporation (the "Corporation") transferable only on the books of the Corporation by the holder hereof, in person or by duly authorized attorney, upon surrender of this Certificate properly endorsed or assigned.*

*A statement of the rights, preferences, privileges and restrictions granted to or imposed upon the respective classes or series of shares of stock of the Corporation and upon holders thereof as established by the Certificate of Incorporation or by any Certificate of Designation of Preferences, and the number of shares constituting each series and the designations thereof, may be obtained by any shareholder upon request and without charge at the principal office of the Corporation.*

*IN WITNESS WHEREOF, the Corporation has caused this Certificate to be signed by its duly authorized officers on November 5, 2018.*

DocuSigned by:

Anthony Sampietro

2471000AD161478...

Anthony Sampietro, President

DocuSigned by:

Amy Frost

161C92A1B539A8

Amy Frost, Vice President and Secretary



**State of Montana**  
Business Standards Division  
Board of Pharmacy

**PHA-PHR-LIC-58632**

Status: **Active**  
Expires: **11/30/2019**

This certificate verifies licensure as:

**COMMUNITY PHARMACY**

Person In Charge: **AMY FROST**

With endorsements of:

\* **TECHNICIAN UTILIZATION PLAN**

\* **DISPENSER OF DANGEROUS DRUGS**

**OSRX INC**  
**1120 KENSINGTON AVE STE E**  
**MISSOULA, MT 59801**



Montana Department of  
**LABOR & INDUSTRY**

RENEW OR VERIFY YOUR LICENSE AT:  
<https://ebiz.mt.gov/pol>

**Renew online at <https://ebiz.mt.gov/pol> by signing in with your username and password.**

The renewal cycle for your board opens 60 days prior to the expiration date on your current license.

Renew your license prior to your expiration date to avoid being charged a late fee(s).

**Remember to maintain your online account information with a password, security question and a valid email address. You can update your account information by accessing the 'Account Management' link when logged in.**

# CERTIFICATE of ACCREDITATION



ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT:

**OSRX Inc**  
MISSOULA, MONTANA

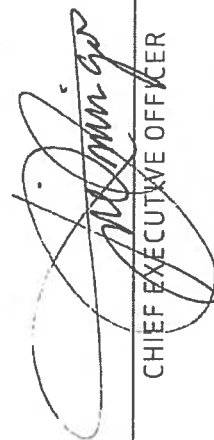
HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS  
THROUGH COMPLIANCE WITH ACHC'S NATIONALLY-RECOGNIZED STANDARDS FOR  
ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

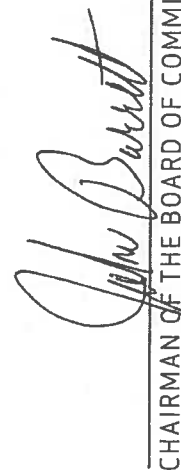
## PHARMACY

### PCAB ACCREDITATION

*For patient specific prescription compounding of  
Non-Sterile Compounding, Ref. USP <795>  
Sterile Compounding, Ref. USP <797>*

FROM May 24, 2019 THROUGH May 23, 2022

  
CHIEF EXECUTIVE OFFICER

  
CHAIRMAN OF THE BOARD OF COMMISSIONERS



 A SERVICE OF ACHC



---

**MONTANA SECRETARY OF STATE**

---

**Return Method:** Email

November 13, 2018

FRANCESCO ROBERT BARBERA  
310 N. INDIAN HILL BOULEVARD  
SUITE 527  
CLAREMONT CA 91711

**CERTIFICATION LETTER**

I, COREY STAPLETON, Secretary of State for the State of Montana, do hereby certify that

**OSRX, Inc.**

filed its Bylaws with this office and has fulfilled the applicable requirements set forth in law. By virtue of the authority vested in this office, I hereby issue this certificate evidencing the filing is effective on the date shown below.

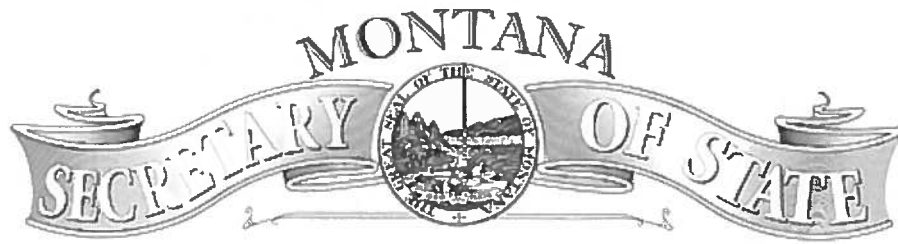
**Certified File Number:** F1099930 - 12045395

**Effective Date:** November 13, 2018

Thank you for being a valued member of the Montana business community. I wish you the best of luck in your future endeavors.

A handwritten signature in black ink, appearing to read "Corey Stapleton".

Corey Stapleton  
Montana Secretary of State



## CERTIFICATE OF FACT

I, **COREY STAPLETON**, Secretary of State for the State of Montana, do hereby certify the following information for the corporation:

**OSRX, Inc.**

Date Incorporated: **April 27, 2018**

Qualification Date: **November 12, 2018**

Term: **Perpetual**

Status: **Active Good Standing**

Jurisdiction: **Delaware**

Purpose: **Compound Pharmacy**

Registered Agent: **Amy Frost**

Agent Physical Address: **1120 Kensington Avenue, Suite E, Missoula, Montana, 59801, United States**

Agent Mailing Address: **1120 Kensington Avenue, Suite E, Missoula, Montana, 59801, United States**

Principal Office Address: **120 Kensington Avenue, Suite E, Missoula, Montana, 59801, United States**

Directors/Officers:

- **Presiding Officer, Anthony Sampietro, 1120 Kensington Avenue, Suite E, Missoula, Montana 59801, United States**
- **Director, Anthony Sampietro, 1120 Kensington Avenue, Suite E, Missoula, Montana 59801, United States**

History Details:

- **Bylaws Filed 11/13/2018**
- **Certificate of Authority Filed 11/12/2018**



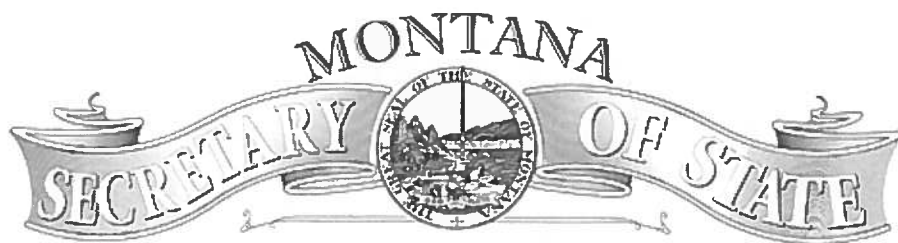
IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of the State of Montana, at Helena, the Capital, this 26th day of April, 2019.

**COREY STAPLETON**

Montana Secretary of State

Certificate Number: 042620191567





## CERTIFICATE OF AUTHORIZATION

I, **COREY STAPLETON**, Secretary of State for the State of Montana, do hereby certify that on **November 12, 2018**, this office issued a Certificate of Authority to:

**OSRX, Inc.**

A foreign corporation organized under the laws of the State or Province of **Delaware**, for a duration of **Perpetual**, to transact business and conduct affairs in the State of Montana.

Payment is reflected in the records of the Secretary of State for all fees owed to the Secretary of State.

No certificate of withdrawal or revocation has been placed on record in this office by said corporation and the records indicate the corporation is in good standing under the laws of the State of Montana.

The Secretary of State cannot certify that tax and penalties owed to this state on record with the Department of Revenue are current. Please contact the Department of Revenue at (406) 444-6900 to obtain information on tax status.



IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of the State of Montana, at Helena, the Capital, this 26th day of April, 2019.

**COREY STAPLETON**

Montana Secretary of State

Certificate Number: 042620190567

# Delaware

The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF INCORPORATION OF "OSRX, INC.", FILED IN THIS OFFICE ON THE TWENTY-SEVENTH DAY OF APRIL, A.D. 2018, AT 1:56 O'CLOCK P.M.

A FILED COPY OF THIS CERTIFICATE HAS BEEN FORWARDED TO THE SUSSEX COUNTY RECORDER OF DEEDS.



6862461 8100  
SR# 20183109291

You may verify this certificate online at [corp.delaware.gov/authver.shtml](http://corp.delaware.gov/authver.shtml)

A handwritten signature in black ink, appearing to read "JBullock", is written over a horizontal line. Below the line, the text "Jeffrey W. Bullock, Secretary of State" is printed.

Jeffrey W. Bullock, Secretary of State

Authentication: 202596870  
Date: 04-27-18



# Montana Department of LABOR & INDUSTRY

Steve Bullock, Governor  
Galen Hollenbaugh, Commissioner

**Business Standards Division**  
Todd Younk, Administrator

## Board of Pharmacy

03/12/2019

OSRX INC  
1120 KENSINGTON AVE STE E  
MISSOULA, MT 59801

I do certify that a standard search of available records of the office of the Montana Board of Pharmacy indicates the following:

<b>Licensee Name:</b>	OSRX INC		
<b>Mailing Address:</b>	1120 KENSINGTON AVE STE E MISSOULA, MT 59801		
<b>License Number:</b>	PHA-PHR-LIC-58632	<b>License Type:</b>	Community Pharmacy License
<b>Original License Date:</b>	03/04/2019	<b>Expiration Date:</b>	11/30/2019
<b>License Status:</b>	Active	<b>Licensure Method:</b>	Application

**Specialties/Endorsements:**

Dispenser of Dangerous Drugs  
Technician Utilization Plan

**Actions:**

Our records show no adverse information concerning this licensee.

This verification is accurate for all disciplinary actions occurring after July 1, 1996. We cannot guarantee the accuracy of disciplinary actions prior to this date. However, every reasonable effort has been made to provide complete and accurate information. For information about related rules and regulations, go to the website below.

Acting on behalf of the Montana Board of Pharmacy.

	
Signature	Title

301 S. Park, PO Box 200513	Helena, MT 59620-0513	(406) 841-2205
Fax (406) 841-2305	TTD (406)444-0532	<a href="http://www.pharmacy.mt.gov">www.pharmacy.mt.gov</a>

**14C**

# 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: Rite Away Pharmacy & Medical Supply

Physical Address: 2235 Thousand Oaks Dr #102 San Antonio, TX 78232

Mailing Address: 2235 Thousand Oaks Dr #102

City: San Antonio

State: TX

Zip Code: 78232

Telephone: 2104902733

Fax: 2104902416

Toll Free Number: 877-254-8507

(Required per NAC 639.708)

E-mail: rohit@riteawaypharmacy.com

Website: www.riteawaypharmacy.com

Managing Pharmacist: Rohit

Chaudhary

License Number: 036530 - New York

### 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: \_\_\_\_\_

**\*\*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.

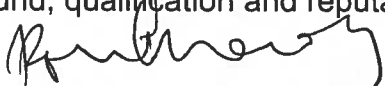
Within the last five (5) years:

- 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

Rohit

Chaudhary

05/10/19

Print Name of Authorized Person

Date

Page 2

Board Use Only

Date Processed: \_\_\_\_\_

Amount: 500.00

## APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

**OWNERSHIP IS A PUBLICLY TRADED CORPORATION**

State of Incorporation: TX  
 Parent Company if any: \_\_\_\_\_  
 Corporation Name: Thousand Oaks Healthcare LLC  
 Mailing Address: 2235 Thousand Oaks Dr #102  
 City: San Antonio State: TX Zip: 78232  
 Telephone: 2104902733 Fax: 2104902416  
 Contact Person: Rohit Chaudhary

If the corporation that holds an ownership interest in the applicant is a publicly traded corporation, the applicant shall identify the officers of that corporation, the date the corporation received its registration with the SEC, the registration number issued and the exchange at which the stock is being traded. You can provide a copy of the SEC report or copy of Form 10-K.

Date of Incorporation: 02/10/2010

Registration number issued: \_\_\_\_\_

Stock Exchange: 0

**Hours of Operation for the pharmacy:**

Monday thru Friday	<u>9</u> am	<u>7</u> pm	Saturday	<u>10</u> am	<u>3</u> pm
Sunday	<u>closed</u> am	_____ pm	24 Hours	<u>NO</u>	

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A

**Must be included with the application for a publicly traded corporation**

Certificate of Corporate Status (also referred to as Certificate of Good Standing). The Certificate is obtained from the Secretary of State's office in the State where incorporated. The Certificate of Corporate status must be dated within the last 6 months.

List of officers and directors.

## APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

**OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION**State of Incorporation: TX

Parent Company if any: \_\_\_\_\_

Mailing Address: 2235 Thousand Oaks Dr #102City: San Antonio State: TX Zip: 78232Telephone: 2104902733 Fax: 2104902416Contact Person: Rohit Chaudhary

For any corporation non publicly traded, disclose the following:

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

a)	<u>Rohit Chaudhary</u>	<u>10705 Canfield Dr Austin, TX 78739</u>
	Name	Address

b)	<u>Naresh Chaudhary</u>	<u>6642 Brady Springs Ln Sugarland, TX 77479</u>
	Name	Address

c)	<u>Jitendra Chaudhary</u>	<u>1310 Osnats Pt San Antonio, TX 78258</u>
	Name	Address

d)	_____	_____
	Name	Address

2) Provide the number of shares issued by the corporation. N/A3) What was the price paid per share? N/A4) 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	<u>9</u> am	<u>7</u> pm	Saturday	<u>10</u> am	<u>3</u> pm
Sunday	<u>closed</u> am	_____ pm	24 Hours	_____	

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, Rohit

Chaudhary

Responsible Person of Rite Away Pharmacy & Medical Supply

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

Rohit

Chaudhary

Print Name of Authorized Person

05/10/19

Date

# AFFIDAVIT for Out-of-State Pharmacy License

STATE OF TEXAS )  
TAYLOR ) ss. COUNTY )

I, Rohit Chaudhary, 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 PIC/Owner for Rite Away Pharmacy & Medical Supply (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.

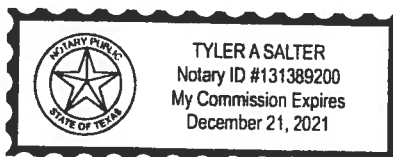
FURTHER AFFIANT SAYETH NOT.

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

Rohit Chaudhary  
 Name

SUBSCRIBED AND SWORN TO  
 before me, a notary public this  
13<sup>th</sup> day of MAY, 2019.

Tyler A. Salter  
 NOTARY PUBLIC



TEXAS STATE BOARD OF PHARMACY  
333 GUADALUPE ST STE 3 500  
AUSTIN TX 78701

RITE AWAY PHARMACY & MEDICAL SUP  
2235 THOUSAND OAKS DR #102  
SAN ANTONIO TX 78232



This certifies that the pharmacy named below is hereby licensed to operate as a  
Class **AS** pharmacy.

License No. **26990**

Expiration Date: **6/30/2020**

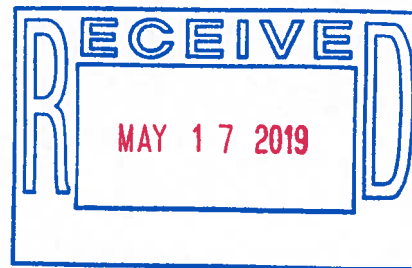
Balances: **1**

**RITE AWAY PHARMACY & MEDICAL SUPPLY**  
**2235 THOUSAND OAKS DR #102**  
**SAN ANTONIO TX 78232**



  
Allison Vordenbaumen Benz, R.Ph., M.S.  
Executive Director/Secretary

**MUST BE DISPLAYED IN FULL PUBLIC VIEW**



## TEXAS STATE BOARD OF PHARMACY

**Re:** Rite Away Pharmacy & Medical Supply

**Address:** 2235 Thousand Oaks Drive #102  
San Antonio, Texas 78232

**License No.:** 26990

**Date Issued:** June 28, 2010

**Licensure Status:** Active

**Expiration Date:** June 30, 2020

**Type of Pharmacy:** Community Sterile Compounding

**Prior Disciplinary Orders:** No

The Texas State Board of Pharmacy maintains records regarding licensure and disciplinary action against a licensee. Rite Away Pharmacy & Medical Supply (Texas Pharmacy License #26990) has not been subject to disciplinary action by the Texas State Board of Pharmacy.

Form Completed by:

*Megan G. Holloway*

Megan G. Holloway  
Assistant General Counsel  
Texas State Board of Pharmacy

May 10, 2019  
Date



The Texas Department of State Health Services, Drugs and Medical Devices Division, Wholesaler Registration, 1100 W. 49<sup>th</sup> Street, Austin, TX 78756, is responsible for issuing registrations to wholesale drug distributors and drug manufacturers in Texas.

**14D**

# 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: 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

- ☐ ☒ 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: \_\_\_\_\_

**\*\*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

SCOTT LUCKOW  
Print Name of Authorized Person

10/23/18  
Date

Page 2

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 LLCMailing Address: 2401 Hassell Rd Ste. 1525City: Hoffman Estates State: IL Zip Code: 601169Telephone Number: 800-783-9655 Fax Number: 877-770-4179Contact 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
<u>Ambreena Vafri</u>	<u>L</u>	<u>97%</u>
<u>Scott Luckow</u>	<u>L</u>	<u>3%</u>

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 pmSaturday 24 am 7 pmSunday 24 am 7 by phone pm24 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.

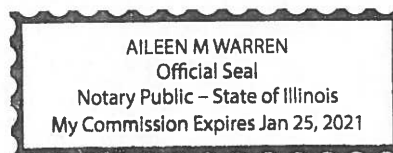
By signing and dating this waiver form, I certify that the information provided is true.

  
Original Signature of Dispensing Practitioner

10/23/18  
Date

## AFFIDAVIT for Out-of-State Pharmacy License

STATE OF ILLINOIS )  
KANE COUNTY ) ss.



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.

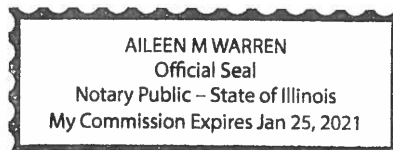
FURTHER AFFIANT SAYETH NOT.

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

Scott Luckow  
 Name

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

Aileen M Warren  
 NOTARY PUBLIC





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



2401 West Hassell Road Suite 1525  
Hoffman Estates IL 60169



800 783 9655



877 770 4179

# Delaware

The First State

Page 1

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.



6225542 8300

SR# 20187166020

You may verify this certificate online at [corp.delaware.gov/authver.shtml](http://corp.delaware.gov/authver.shtml)

A handwritten signature in black ink, appearing to read "JBULLOCK", is written over a horizontal line. Below the line, the text "Jeffrey W. Bullock, Secretary of State" is printed.

Jeffrey W. Bullock, Secretary of State

Authentication: 203631232

Date: 10-17-18

File Number

0616916-3



***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 .***



Authentication #: 1831202040 verifiable until 11/08/2019  
 Authenticate at: <http://www.cyberdriveillinois.com>

*Jesse White*

SECRETARY OF STATE



Sent to:  
DPR  
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](mailto:Aileen.warren@psinfusion.com)  
 800-783-9655



2401 West Hassell Road Suite 1525  
 Hoffman Estates IL 60169



800.783.9655



877.770.4179





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