

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: Buy-Rite Drugs, Inc.
Physical Address: 401 Corsbie St. NW
Mailing Address: PO Box 217
City: Hartselle State: Alabama Zip Code: 35640
Telephone: 256-773-7319 Fax: 256-773-5115
Toll Free Number: 844-447-5422 (Required per NAC 639.708)
E-mail: stricmr@me.com Website: None
Managing Pharmacist: Mike Strickland License Number: AL # 7277

TYPE OF PHARMACY **AND**

SERVICES PROVIDED

Yes/No

- ☒ ☐ Retail
☐ ☒ Hospital (# beds ____)
☐ ☒ Internet
☐ ☒ Nuclear
☐ ☒ Ambulatory Surgery Center
☐ ☒ Community
☒ ☐ Other: Veterinary Only

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: Veterinary Only

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

97003

APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

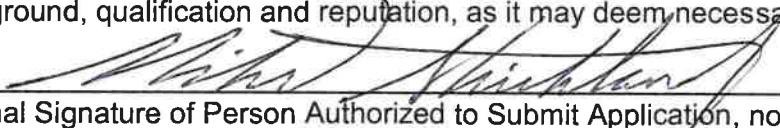
Within the last five (5) years:

- 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

Mike Strickland
Print Name of Authorized Person

08/05/2016
Date

Page 2

Board Use Only

Date Processed: _____

Amount: \$500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: Alabama

Parent Company if any: Buy-Rite Drugs, Inc.

Mailing Address: PO Box 217

City: Hartselle State: Alabama Zip: 35640

Telephone: 256-773-7319 Fax: 256-773-5115

Contact Person: Mike Strickland

For any corporation non publicly traded, disclose the following:

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

a) Michael Rowe Stickland 1100 Corsbie St. SW, PO Box 8, Hartselle, AL 35640 (100% owner)
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. 10,000

3) What was the price paid per share? \$1.00

4) What date did the corporation actually receive the cash assets? 8/15/1991

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

List any physician shareholders and percentage of ownership.

Name: None %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 5 pm

Saturday 9 am 5 pm

Sunday closed am _____ pm

24 Hours on call

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

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Michael R. Strickland

Responsible Person of Buy-Rite Drugs, 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

Mike Strickland
Print Name of Authorized Person

8/5/2016
Date

SUSAN ALVERSON R.PH.
EXECUTIVE SECRETARY

LOCATION:
111 VILLAGE STREET
BIRMINGHAM, AL 35242

(205) 981-2280
(205) 981-2330 FAX
WWW.ALBOP.COM

ALABAMA BOARD OF PHARMACY



MEMBERS 2016

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TREASURER

DONNA YEATMAN, R.PH

RALPH E. SORRELL, R.PH

December 1, 2016

Mike Strickland, Pharmacist in Charge
Buy-Rite Drugs
401 Corsbie Street NW
Hartselle, AL 35640

Dear Mr. Strickland,

On 10/05/2016 and 10/27/2016, the Alabama State Board of Pharmacy (ALBOP) performed a routine USP 795 & 797 inspection for Buy-Rite Drugs (AL # 101957). This letter is to report Buy-Rite Drugs is approved to continue sterile and non-sterile compounding within the regulations of USP 795 & 797 and the Alabama State Board of Pharmacy (ALBOP) **contingent on correcting deficiencies** observed during the inspection. The USP 797 sterile compounding inspection was completed by Investigator Todd Brooks and I completed the USP 795 portion. During the inspection several deficiencies were noted and require corrective action to achieve USP 795/797 standards and maintain ALBOP approval for non-sterile & sterile compounding.

Compounding Areas of Focus/Correction

1. The information on each Certificate of Analysis (COA) should be verified for completeness and quality. Each COA should be filed and maintained in compliance with USP, FDA and ALBOP requirements. **ALL Products must have a legitimate analysis** prior to being utilized in compounding. COAs indicating "for information purposes only" are not acceptable. Lack of an adequate COA will be considered a failure to ensure quality, strength and purity of the chosen compounding ingredient. Lack of documentation validating compendial standards is considered adulteration. Immediate Action Required
2. Extending Beyond Use Dating on sterile compounded product "lots" must be based on not only stability testing, but third party sterility and endotoxin testing. Extended BUDs based on external studies or journal articles are not sufficient due to variables in facilities, personnel, environment, processes, API, etc. Immediate Action Required

3. Multiple dose containers (such as compounded stock solutions) were possibly being drawn from for greater than 28 days past first manipulation. These multi-dose containers did not indicate initial entry date or expiration date. Immediate Action Required
4. Bi-annual environmental testing must identify ALL discovered microorganisms down to a genus level to detect highly pathogenic CFUs that require an immediate response regardless of whether action levels are exceeded. To be implemented going forward
5. ALL sterilization filters must be integrity tested (according to manufacturer guidelines) and recorded. Immediate Action Required
6. Documented policies/agreements between the facility and brokers used to obtain product for compounding purposes must be in place and understood by both parties. The broker should completely understand and be held to the facility's quality standards. To be implemented going forward
7. The pharmacy needs to develop a more comprehensive "complaint/compound failure" file. This file should contain any compound quality control issues reported by patient, compounder, analytics facility or other party involved with any process of a compounded product. Any failure should have a documented investigative process and a root cause analysis if necessary. To be implemented going forward

The inspection was pleasant and the staff was forthcoming and eager to assist. This inspection is meant to communicate the current expectations of the Alabama Board of Pharmacy and provide the safest and most efficacious products to the public. USP 800 has been published in its final form—it is not fully enforceable until July 2018 to give facilities time to be fully compliant with the chapter. Some states have proposed or adopted to enact USP 800 at an earlier date. Alabama expects hazardous compounders to be in compliance with the current USP 797/NIOSH and developing an action plan to evolve into USP 800 compliance by the enforcement date. I also want to remind you that USP 797 is under revision and drafted modifications do not supersede the current USP 797 until it is published in final form.

Further details may be found on the USP 795 inspection & USP 797 inspection forms provided to you.

Please feel free to contact Investigator Todd Brooks or me with any questions or concerns regarding the inspection or compounding.

All the Best,



Cristal Anderson, Pharm.D.
Director of Compliance
Alabama State Board of Pharmacy

CANDERSON@ALBOP.COM

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

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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: VERTISIS LUSTON PHARMACY, LLC
Physical Address: 9343 E. BAHIA DR., STE # 200
Mailing Address: " SAME "
City: SCOTTSDALE State: AZ Zip Code: 85260
Telephone: 602-362-2190 Fax: 480-625-4276
Toll Free Number: 888-285-5841 (Required per NAC 639.708)
E-mail: VERTESIS@VERTESIS.COM Website: WWW.VERTESIS.COM
Managing Pharmacist: JOSE DASTAS License Number: 13907

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,**

96929

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

DEVO SANTO
Print Name of Authorized Person

3/14/17
Date

Page 2

Board Use Only

Date Processed:

5/22/17

Amount:

\$500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: ARIZONA
Parent Company if any: VERTISTIS GROUP, LLC
Mailing Address: 9343 E. BANIA DR., STE #200
City: SCOTTSDALE State: AZ Zip: 85260
Telephone: 602-362-2190 Fax: 480-625-4276
Contact Person: BREAN HARRISON

For any corporation non publicly traded, disclose the following:

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

a) VERTISTIS GROUP, LLC 9343 E. BANIA DR, STE #200
Name Address SCOTTSDALE, AZ 85260
b) _____
Name Address
c) _____
Name Address
d) _____
Name Address

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

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

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

- 5) Provide a copy of the corporation's stock register evidencing the above information - N/A

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 5 pm Saturday _____ am _____ pm
Sunday _____ am _____ pm 24 Hours _____

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

STATE OF ARIZONA



Office of the CORPORATION COMMISSION

CERTIFICATE OF GOOD STANDING

To all to whom these presents shall come, greeting:

I, Ted Vogt, Executive Director of the Arizona Corporation Commission, do hereby certify that

*****VERTISIS CUSTOM PHARMACY LLC*****

a domestic limited liability company organized under the laws of the State of Arizona, did organize on the 20th day of January 2016.

I further certify that according to the records of the Arizona Corporation Commission, as of the date set forth hereunder, the said limited liability company is not administratively dissolved for failure to comply with the provisions of A.R.S. section 29-601 et seq., the Arizona Limited Liability Company Act; and that the said limited liability company has not filed Articles of Termination as of the date of this certificate.

This certificate relates only to the legal existence of the above named entity as of the date issued. This certificate is not to be construed as an endorsement, recommendation, or notice of approval of the entity's condition or business activities and practices.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Arizona Corporation Commission. Done at Phoenix, the Capital, this 20th day of March, 2017, A. D.



A stylized signature of Ted Vogt, consisting of a large, sweeping 'T' and 'V'.

Ted Vogt, Executive Director


By: 1619692

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Dino Prato
Responsible Person of Verfisis Custom 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

DINO PRATO
Print Name of Authorized Person

3/14/17
Date

Send to State Board of Pharmacy for Completion: A separate letter is acceptable.
Do not return with application unless it has been completed by the licensing agency.

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

LICENSE VERIFICATION

Name: VERTISIS CUSTOM PHARMACY, LLC
Address: 9343 E. BAHIA DR., STE #200
City: SCOTTSDALE State: AZ Zip: 85260
I hereby authorize the _____ to furnish to the Nevada
State Board of Pharmacy, the information requested below.
Signature of Applicant [Signature]

THIS FORM MUST BE FORWARDED TO THE HOME STATE
LICENSING AGENCY FOR COMPLETION. DO NOT WRITE BELOW THIS LINE

License Number	License Status	Date License Issued	Date License Expires
<u>4007042</u>	<u>Open</u>	<u>October 13, 2016</u>	<u>October 31, 2017</u>

Has this license been encumbered in any way? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Type of Encumbrance: (if any) <input type="checkbox"/> Revoked <input type="checkbox"/> Surrendered <input type="checkbox"/> Limited <input type="checkbox"/> Suspended <input type="checkbox"/> Restricted <input type="checkbox"/> Probation Please attach copies of any pertinent legal documents
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USE REVERSE SIDE OF THIS FORM FOR EXPLANATIONS IF NECESSARY

Has the applicant been convicted of any federal, state or local laws
relating to drug samples, wholesale or retail drug distribution, or
distribution of controlled substances? (If yes, please explain) ☐ Yes ☒ No
Has the applicant furnished any false or fraudulent material in any
applications made in connection with drug manufacturing or
distribution? (if yes, please explain) ☐ Yes ☒ No
Have any inspections of the applicant resulted in deficient ratings?
(If yes, please explain) ☐ Yes ☒ No
Has applicant met all licensing requirements of your state?
(If no, please explain) ☒ Yes ☐ No

Signature of State Official	Title	State	Date	State S
<u>[Signature]</u>	<u>Program Project Specialist</u>	<u>Arizona</u>	<u>May 9, 2017</u>	

