VistaPharm®
A PAI PHARMA COMPANY

Customer Information Packet

Welcome to the VistaPharm family. We are very excited to have the opportunity to serve you moving forward, but we need to get a few housekeeping items out of the way to get your account set up. If you have questions, or if you need assistance in any way while completing this document, please give us a call at 877.530.1633.

The following information and documents are required for us to process and ship your order. Please use the check list below to ensure we have everything you need on file before placing your first order:

- ☐ A completed Customer Information Packet (this document)
- ☐ A copy of your current DEA Registration Certificate
- ☐ A copy of your current State Board of Pharmacy License and/or State Registration for controlled and/or prescription products, if applicable.
- ☐ A copy of your SAMHSA approval letter or license.
- ☐ A signed Power of Attorney document that allows for someone other than the registrant or registrant's agent to place orders.*
- ☐ A DEA Authorized Receiver form that allows for someone other the registrant, or registrant's agent to sign for shipments.†

*For your convenience, we have included a form for recording all POAs on page 7 of this packet. If you have more than five personnel for ordering, please use multiple pages of this document.

†For your convenience, we have included a form for receiving shipments on page 8 of this packet. If you have more than ten personnel for receiving, please use multiple pages of this document.

The above information and documents will need to be updated on a regular basis when DEA Registration and State Licenses are renewed and when personnel authorized to purchase or receive are deleted or added.

The above information, a copy of your current DEA Registration Certificate and a copy of your current State License/Registration are to be sent to order@paipharma.com.

Please note that every schedule II order received by VistaPharm, LLC must be accompanied by a properly executed DEA Form 222.

The above information and documents are provided by:

Name:

Title:

Date:

Signature:

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Customer Information Sheet

Date:

Facility Name:

Billing Address:

Shipping Address:

(Shipping Address must be exactly as on DEA Registration and DEA Form 222)

DEA Registrant Agent Name:

Telephone:

Fax #:

Contact:

Title:

Primary Email Address:

State Tax ID:

Narcotic Treatment Center (check one): ○ Yes ○ No

Client Population (on VistaPharm product):

Patient Average Dose:

(Product list provided on next page)

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Customer Information Sheet
(continued)

Monthly Order Average by Product

To ensure we are well prepared to serve your company, please provide the best estimate you can for your locations average monthly order per product that you will be ordering from VistaPharm.

Methadone Products	Size/Qty	Ordered
Methadone HCl 10 mg Tablet	10 mg bottle (100 count)	
Methadone HCl 10 mg/mL Concentrate (Dye & sugar free)	1,000 mL bottle	
Methadone HCl 10 mg/mL Concentrate (Cherry-flavored)	1,000 mL bottle	
Methadone HCl 10 mg/mL Concentrate (Cherry-flavored)	4,000 mL bottle	
Methadone HCl Powder	100 GM bottle	
Methadone HCl Tablet for Oral Suspension 40 mg	40 mg bottle (100 count)	

Buprenorphine Products	Size/Qty	Ordered
Buprenorphine Sublingual 2 mg Tablet	2 mg bottle (30 count)	
Buprenorphine Sublingual 8 mg Tablet	8 mg bottle (30 count)	

Buprenorphine and Naloxone Products	Size/Qty	Ordered
Buprenorphine and Naloxone Sublingual 2 mg/0.5 mg Tablet	2 mg/0.5 mg bottle (30 count)	
Buprenorphine and Naloxone Sublingual 8 mg/2 mg Tablet	8 mg/2 mg bottle (30 count)	
Buprenorphine and Naloxone Sublingual Film 2 mg/0.5 mg	30 films per carton	
Buprenorphine and Naloxone Sublingual Film 4 mg/1 mg	30 films per carton	
Buprenorphine and Naloxone Sublingual Film 8 mg/2 mg	30 films per carton	
Buprenorphine and Naloxone Sublingual Film 12 mg/3 mg	30 films per carton	

Other Products	Size/Qty	Ordered
APLISOL® (tuberculin purified protein derivative injection) 5TU/0.1mL	1 mL (10 tests)	
APLISOL® (tuberculin purified protein derivative injection) 5TU/0.1mL	5 mL (50 tests)	
Naltrexone HCl 50 mg Tablet	50 mg bottle (30 count)	

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Clinic Name:

DEA Number:

Point of Contact

This list will act as a reference for our team throughout the process of serving you if we need to request additional information or provide you with information.

Primary Contact

First Name:

Last Name:

Title:

Email Address:

Phone Number:

Primary Packing Slip

First Name:

Last Name:

Title:

Email Address:

Phone Number:

If you would prefer for this person to be the point of contact for all areas, please check here.

○ Yes ○ No

Billing Information

First Name:

Last Name:

Title:

Email Address:

Phone Number:

Ordering Information

First Name:

Last Name:

Title:

Email Address:

Phone Number:

Additional Packing Slip Emails

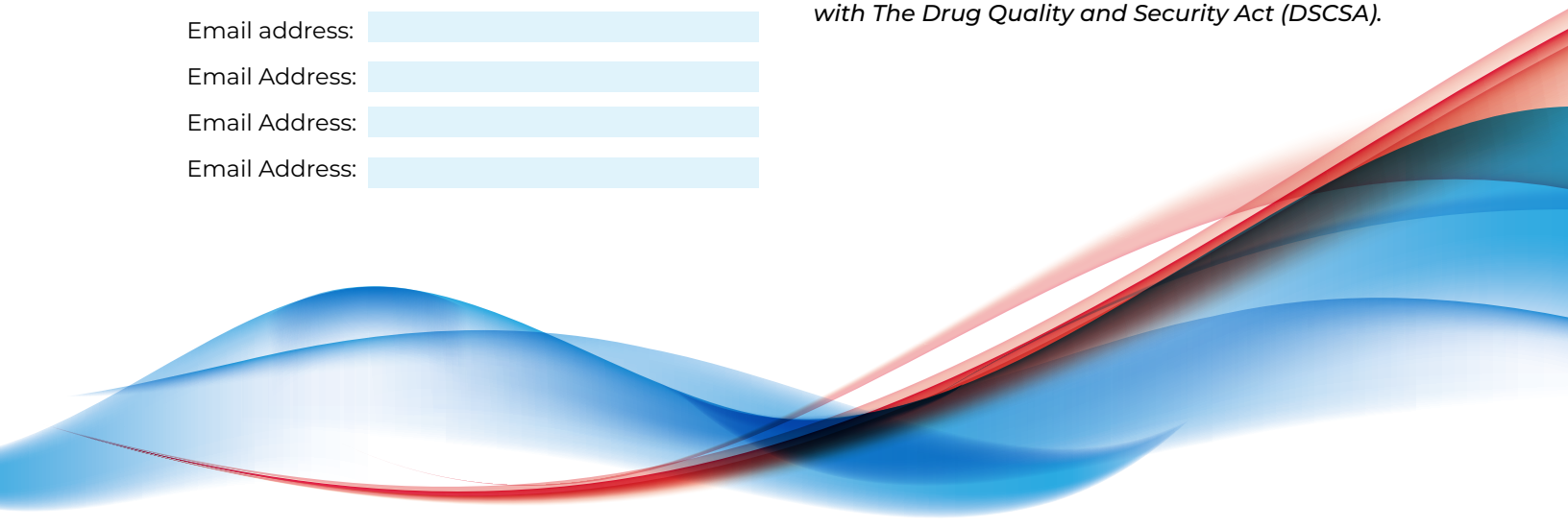
Email address:

Email Address:

Email Address:

Email Address:

**REQUIRED* Providing an email address for the packing slips is a requirement to stay compliant with The Drug Quality and Security Act (DSCSA).*



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Business Credit Application

Do you plan to order $5,000.00 or more per month from VistaPharm? ○ Yes ○ No

If yes, please complete the following:

Name/Address:

Last: First: M.I.

Title:

Company Name:

Tax I.D. Number:

Address:

City:

State:

Zip Code:

Phone:

Company Information:

Business Formation Type: ○ Corporation ○ Proprietorship ○ LLC ○ Partnership ○ Other

State: If Applicable, Parent Company Name:

In Business Since:

Address:

City: State: Zip Code:

Phone:

Bank References:

Institution Name	Contact Name	Phone Number
Institution Name	Contact Name	Phone Number
Institution Name	Contact Name	Phone Number

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Business Credit Application

Trade References:

Institution Name	Contact Name	Phone Number
Institution Name	Contact Name	Phone Number
Institution Name	Contact Name	Phone Number

Financial Information:

Have you or any of your corporate officers ever filed for bankruptcy protection? ○ Yes ○ No

Is your company subject to any litigation? ○ Yes ○ No

If yes, please describe:

Requested Credit Limit:

Requested Credit Limit ○ Monthly ○ Quarterly ○ Annually

*Unless otherwise noted, all payments are due on a net30 agreement.

I hereby declare that the above information is true, correct, and complete and is given to induce VistaPharm to extend credit. I authorize VistaPharm to make such credit investigations as VistaPharm sees fit, including contacting the above references and obtaining any necessary credit reports. I authorize all references, financial institutions, and credit reporting agencies to disclose to VistaPharm any and all information pertaining to the financial and credit history of my company and myself.

I have read the terms and conditions stated above and agree to all of those terms and conditions.

Name: Company:

Title:

Date:

Signature:

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Power of Attorney for DEA Order Forms and Orders for Narcotics

Date:

Registrant Name / Facility Name:

DEA Registration Number:

DEA Registrant Agent Name:

Address:

City:

State:

Zip / Postal Code:

Contact Name:

Phone Number:

Email Address:

The following individuals are authorized to sign DEA Form 222 and/or Buprenorphine or Buprenorphine/Nalaxone order forms used to order scheduled narcotics.

Name: Signature: _____

Name: Signature: _____

Name: Signature: _____

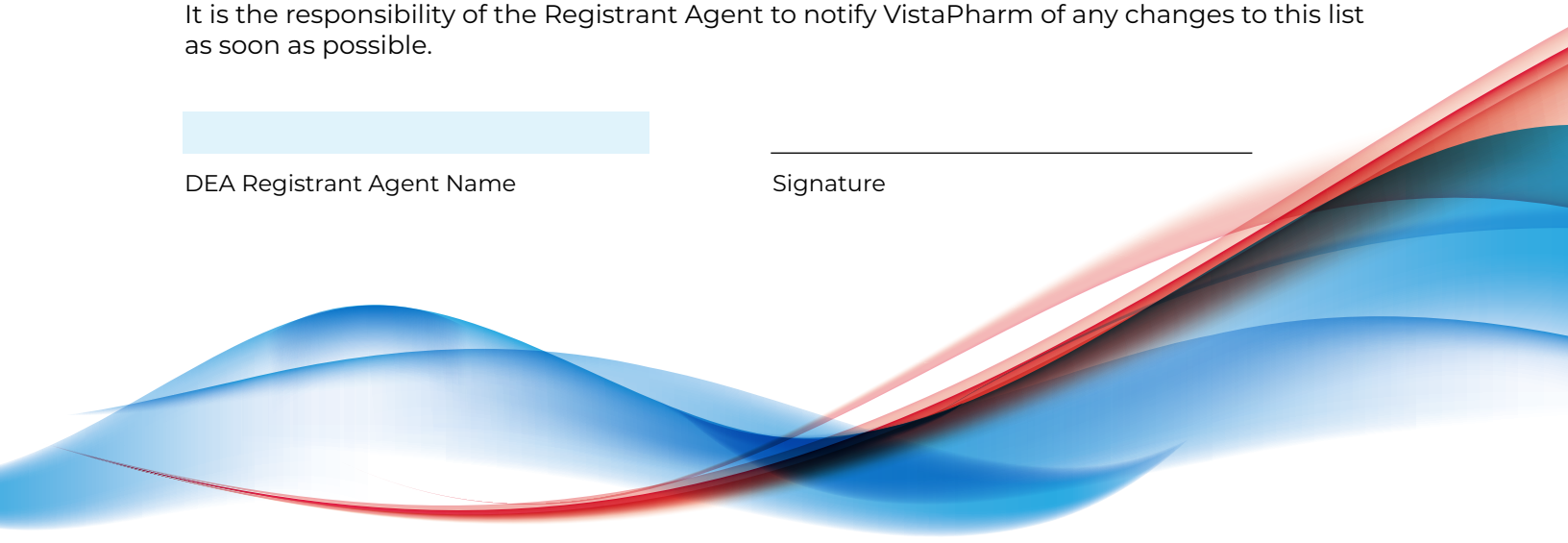
Name: Signature: _____

Name: Signature: _____

It is the responsibility of the Registrant Agent to notify VistaPharm of any changes to this list as soon as possible.

_____ _____

DEA Registrant Agent Name Signature



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DEA Authorized Receiver Form

Date:

Registrant Name / Facility Name:

DEA Registration Number:

DEA Registrant Agent Name:

Address:

City:

State:

Zip / Postal Code:

Contact Name:

Phone Number:

Email Address:

The following individuals are authorized to receive and sign for shipments.

Name:		Name:	
Name:		Name:	
Name:		Name:	
Name:		Name:	
Name:		Name:	

It is the responsibility of the Registrant Agent to notify VistaPharm of any changes to this list as soon as possible.

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Suspicious Ordering Monitoring Questionnaire

VistaPharm's Suspicious Order Monitoring Program customer questionnaire is an integral part of our SOM Program. Please complete the questionnaire in its entirety and submit. Failure to submit a completed questionnaire may result in delayed shipments.

General Information

Company Name:

Address:

City / Town:

State:

Zip / Postal Code:

Country:

Email Address:

Phone Number:

If suspicious ordering is suspected, please list two individuals we can contact.

Primary Contact

Name:

Title:

Email Address:

Phone Number:

Secondary Contact

Name:

Title:

Email Address:

Phone Number:

Are you currently accredited by Joint Commission, CARF, or another SAMHSA approved accreditation body?

○ Yes ○ No

Are you currently certified by Joint Commission or CARF?

○ Yes ○ No

What is the Narcotic Treatment Program DEA license number for your facility?

What is the state license number for your facility (if applicable)?

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Suspicious Ordering Monitoring Questionnaire (continued)

Please provide the name and license number of the pharmacist in charge (if applicable).

Please provide the name and license number of the medical director or physician in charge.

If OTP is new in the past 12 months, was it owned by another individual?

Yes No

If yes, please provide additional information.

Does the owner operate/own any other OTPs?

Yes No

(If yes, please provide DEA numbers and State license numbers)

To your knowledge, is registrant or any practitioner/employee currently under investigation by any licensing authority, including the DEA?

Yes No

If yes, please provide additional information.

Has the registrant or any practitioner/employee had a license or registration denied, revoked, or suspended by any licensing authority, including DEA, or been the subject of administrative action (including consent agreement, memorandum of agreement, memorandum of understanding, order to show cause, or immediate suspension order) by any such authority?

Yes No

If yes, please provide additional information.

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Suspicious Ordering Monitoring Questionnaire (continued)

Please provide the names of all pharmaceutical wholesale drug distributors that you have used in the past 12 months and the percentage of controlled drugs you intend to continue to purchase from each distributor.

Were you ever cut off from doing business with any pharmaceutical wholesale distributor/manufacturer?

○ Yes ○ No

If yes, please provide additional information.

Do you perform regular background checks on the employees that handle controlled substances?

○ Yes ○ No

The acceptance of delivery of narcotic substances by a narcotic treatment program shall be made only by a licensed practitioner employed at the facility or other authorized individuals designated in writing. At the time of delivery, the licensed practitioner or other authorized individual designated, in writing, excluding persons currently or previously dependent on narcotic drugs, shall sign for the narcotics and place his specific title (if any) on any invoice (including packing slip or official DEA records). Please attach a current list of those personnel that are authorized, in writing, to receive and secure the narcotic substances to be kept on file in VistaPharm's records. **OTP is responsible for ensuring that VistaPharm is provided updated lists of authorized personnel as changes/turn-over occur.**

Printed name:

Title:

Date:

Signature: