PHARMA
PRECISION & QUALITY
- 503B -

REGISTRATION PACKET

2024

Who we are:

Located in Brooksville, Florida, PQ Pharmacy is a USP 800 and CGMP compliant FDA-Registered 503B Outsourcing Facility. We provide high-quality sterile compounded products in bulk to qualified healthcare facilities. The quality assurance program at our 12,000 square-foot facility encompasses compliance with FDA regulations, CGMP standards, and a robust environmental monitoring program. We take pride in going above and beyond industry standard. All batches of medication are tested by an independent lab for multiple standards such as sterility and potency.

15215 Technology Dr. Brooksville, FL 34604
www.pqpharmacy.com
order@pqpharmacy.com
(352) 477-8977
(877) 456-4512

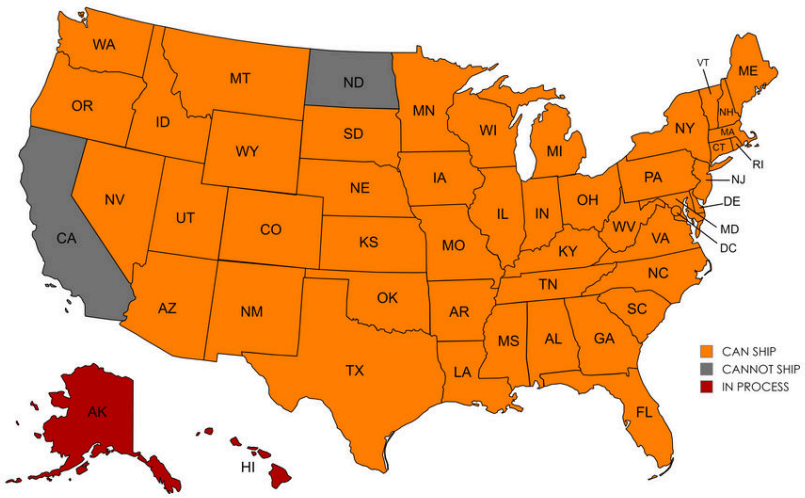
NEW ACCOUNT CHECKLIST:

*All paperwork & copies of licensure MUST be completed & emailed to your rep. If not complete, this will delay your onboarding process.

- ☐ **NEW ACCOUNT FORM W/ GROUP / REP NAME POPULATED**
- ☐ **SIGNED PHYSICIAN STATEMENT**
- ☐ **CREDIT CARD AUTHORIZATION FORM**
- ☐ **COPY OF PRESCRIBER'S MEDICAL LICENSE / PHARMACY LICENSE**
- ☐ **DEA PERMIT**
- ☐ **LETTER OF MEDICAL DRUG NECESSITY (DUE TO SHORTAGE)**
- ☐ **ORDER FORM w/ PRE-POPULATED PRICING, SALES GROUP & SALES REP**
- ☐ **GOOGLE SCREENSHOT OF HEALTHCARE FACILITY TO MATCH SHIPPING ADDRESS**
- ☐ **LETTER OF ENGAGEMENT**

- ***Please allow up to 72 hours for new accounts to be successfully set up in our system and ready to order.***

LICENSED STATES LIST:



NEW ACCOUNT INFORMATION

*Please email completed form to your rep.
If you do not have a rep, please email to info@pqpharmacy.com

DATE : _____ **GROUP / REP NAME :** _____

LICENSED HEALTHCARE PROVIDER INFORMATION:

Facility: _____
Contact: _____
Phone: _____
Address: _____
City, State, Zip: _____
AP Contact: _____
AP Phone: _____
Email: _____

SHIPPING INFORMATION: ☐ SAME AS ABOVE

Facility: _____
Contact: _____
Phone: _____
Address: _____
City, State, Zip: _____

METHOD OF PAYMENT:

(ACH is preferred, payment link can be emailed or kept securely on file)

ACH:

Bank Name:	Account #:	Routing #:

CREDIT CARD: Please note there is an additional 3% processing fee with credit card

Credit Card #:		Accept: AMEX / Mastercard / Visa
Name on Card:		Expiration:
CVV:		
Billing Address:		
City:	State:	Zip:

FACILITY INFORMATION:

License #:	Expiration:
DEA #:	Expiration:

Signature: _____

Date: _____

FACILITY STATEMENT REGARDING BONA FIDE HEALTHCARE PROVIDER / PATIENT RELATIONSHIP REQUIREMENTS

Dear Facility:

In order to purchase sterile pharmaceutical products from PQ Pharmacy LLC, we require the following acknowledgement: that our authorized healthcare professionals agree that the following elements are satisfied prior to sending PQ Pharmacy LLC an order for compounded / shortage products. For purposes of state law, many state authorities, with the endorsement of medical societies, consider the existence of the following three elements as an indication that a legitimate healthcare provider / patient relationship has been established:

1. **Medical Facility follows state and federal guidelines when using PQ Pharmacy products.**
2. **The facility (Hospital, Pharmacy, Medical Office) agrees to purchase compounded medications for Patient Use from PQ Pharmacy LLC under the guidelines required per Florida rule 64B16-27.700.**
3. **The healthcare provider has created and maintained records of the patient's condition in accordance with medically accepted standards.**
4. **Patients receiving PQ products have had the following:**
   a. **a physical examination by provider (Pharmacy will have a patient specific prescription from a physician)**
   b. **a medical history by provider conducted in person or telehealth (excluding questionnaire driven telehealth models)**
   c. **a medical complaint**

I agree that all orders placed with PQ Pharmacy LLC meet the criteria above. I agree that there is no other agreement written, oral or otherwise that negates this one.

I hereby certify that the foregoing information is correct, and products will be sold or dispensed only to members of this account and only for the institution's "own use" within the meaning of 15 USC 13C (52 Stat. 446). Violation of any of these terms is a material breach of the agreement and the applicant shall be liable and hold harmless PQ Pharmacy for any cost and damages arising there from. Lastly, I acknowledge that PQ Pharmacy is not licensed in California and North Dakota, and PQ Pharmacy products cannot be sold or transferred to those states.

I agree to abide by "prohibition of Wholesaling by 503B Outsourcing Facilities" FDA Guidance published in June 2023. Link: https://www.fda.gov/media/169838/download

Facility Signature: _____

Date: _____

CREDIT CARD AUTHORIZATION FORM

(If paying by credit card)

I (we) hereby authorize PQ Pharmacy LLC to make recurring charges to my Credit Card listed on the New Account Form, and, if necessary, initiate adjustments for any transactions credited/debited in error. I (we) acknowledge a 3% processing fee with all credit card transactions. This authority will remain in effect until PQ Pharmacy LLC is notified by me (us) in writing to cancel it in such time as to afford PQ Pharmacy and/or Credit Card Company a reasonable opportunity to act on it. All receipts are sent directly to the cardholder within 24 hours. All records are kept in a secure file electronically password protected and accessible to authorized personnel only.

Facility Signature : _____

Date : _____

LETTER OF MEDICAL DRUG NECESSITY

(DUE TO SHORTAGE)

Date: ____ /____ /_____

To: **503B FDA Registered Outsourcing Facility**
PQ Pharmacy
15215 Technology Drive
Brooksville, FL 34604

Licensed Medical Facility / Provider: _____

Licensed Medical Facility / Provider: _____

Licensed Medical Facility / Provider: _____

Licensed Medical Facility / Provider Address: _____

Prescriber: _____

Requested Drug:

☐ **Semaglutide Base and/or Other:** _____

☐ **Tirzepatide Base**

Reason for Request: We have immediate patients that need to be supplied as soon as possible. Our patients are unable to receive this medication due to shortages. If you can ship these products to our healthcare facility or pharmacy, that will help our practice and patients meet their medical needs and improve their prognosis.

Authorized Healthcare Provider Signature : _____

Authorized Healthcare Provider NPI or License # : _____

LETTER OF ENGAGEMENT

DATE: _____

PQ REP: _____

PHARMACY/PHYSICIAN/CLINIC/FACILITY

NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____ **FAX:** _____

EMAIL: _____

I am currently in negotiations with the above-named PQ representative, and we are actively discussing products and agreement. This is the only PQ representative that I am working with. My signature on this form is not a commitment or guaranty that I will become a customer of PQ Pharmacy. This Letter of Engagement is sufficient for 30 days.

Name of Facility Contact: _____

Signature: _____