PQ PHARMACY™
PRECISION & QUALITY

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% to 5% 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/ ACH AUTHORIZATION FORM

I (we) hereby authorize PQ Pharmacy LLC to make recurring charges to my Credit Card or ACH listed on the New Account Form, and, if necessary, initiate adjustments for any transactions credited/debited in error. I (we) acknowledge a 3% to 5% 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 : ______________________