595 N. Smith Avenue | Corona CA 92880
Phone: (951) 270-0816 | **Fax:** (800) 563-6967
www.aidarex.com

PRACTICE PROFILE

Complete the below information in its entirety. Contact Aidarex with any inquiries.

SALES AGENT/ACCOUNT REPRESENTATIVE _____ REQUESTED GO LIVE DATE: _____

PRACTICE NAME: _____

PRACTICE TYPE/SPECIALTY: _____

(Example: Urgent Care, Family Practice, Orthopedics, etc.)

PRACTICE INFORMATION

Check if 'Ship To' is the same as the 'Bill To' ☐

SHIP TO ADDRESS		BILL TO ADDRESS	
CONTACT:		CONTACT:	
ADDRESS 1:		ADDRESS 1:	
ADDRESS 2:		ADDRESS 2:	
CITY:		CITY:	
STATE:	ZIP:	STATE:	ZIP:
PHONE:		PHONE:	
ALT PHONE:		ALT PHONE:	
FAX:		FAX:	
EMAIL:		EMAIL:	
WEBSITE:		WEBSITE:	

PROVIDER INFORMATION

PRIMARY PROVIDER NAME: _____

STATE MEDICAL LICENSE NUMBER: _____ Exp. Date: _____

☐ N/A STATE DISPENSING LICENSE NUMBER: _____ Exp. Date: _____

☐ N/A STATE CONTROLLED DISPENSING LICENSE: _____ Exp. Date: _____

☐ N/A DEA LICENSE NUMBER: _____ Exp. Date: _____

REGISTERED WITH THE STATE'S PRESCRIPTION DRUG MONITORING PROGRAM? *(PDMP)* ☐ YES ☐ NO ☐ N/A

PLEASE INCLUDE THE ORIGINAL COPY OF ALL LICENSURE WHEN SUBMITTING THE PRACTICE PROFILE FOR REVIEW/APPROVAL. ONLINE VERIFICATIONS OF LICENSURE WILL NOT BE ACCEPTED EXCEPT WHERE APPLICABLE.

Is there more than one individual dispensing at this Practice? ☐ YES ☐ NO

*If yes, please fill out the table below with all additional staff, who are licensed and authorized and will be dispensing **at this Practice**.*

	FULL NAME	MEDICAL LIC NUMBER	EXPIRY DATE	DEA LIC NUMBER	EXPIRY DATE
1.					
2.					
3.					
4.					
5.					

PRESCRIBING/DISPENSING ACTIVITIES

1. Will controlled substances be purchased through Aidarex for dispensing to patients? ☐ YES ☐ NO

   If yes, which Schedule(s): ☐C2 ☐C2N ☐C3 ☐C3N ☐C4 ☐C5

2. Estimate the number of patients to be **dispensed** to per week: _____
3. Estimate the average **number of bottles dispensed** per week: _____
   a. What % of the bottles in answer '4.' are Controlled: _____ %
   b. What % of the bottles in answer '4.' are Non-Controlled: _____ %

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4. Does the Provider currently use another supplier to purchase pharmaceuticals? ☐ YES ☐ NO
5. Method of dispensing to be used: ☐Dispensing Software (MD Scripts) ☐ Manual Dispensing
6. Will dispensing records be properly documented and maintained (either electronically or manually)? ☐ YES ☐ NO
7. Has the Provider/Practice experienced any theft or loss of any pharmaceuticals? ☐ YES ☐ NO
   If 'yes', explain: _____
8. Will the Provider have measures in place to prevent the **diversion** of prescription drugs? ☐ YES ☐ NO
9. Will the Provider have measures in place to prevent the **addiction** to prescription drugs? ☐ YES ☐ NO
10. Will the Provider engage in **online** selling/prescribing/dispensing? ☐ YES ☐ NO
11. Will the Provider ensure that the applicable state/federal reports are submitted appropriately? ☐ YES ☐ NO ☐ N/A
12. If ordering **C2s**, will the Provider ensure that a 222 form is used for placing orders? ☐ YES ☐ NO ☐ N/A
13. If ordering **C2s**, does the Provider facilitate the minimum security requirements required by the DEA, to store and dispense C2 substances? (https://www.deadiversion.usdoj.gov/pubs/manuals/sec/sec_req.htm) ☐ YES ☐ NO ☐ N/A
14. For **all controlled** substances, does the Provider ensure that Form DEA 106 will be utilized to report stolen or lost controlled substances? ☐ YES ☐ NO ☐ N/A
15. For **all controlled** substances, is access to these restricted to authorized individuals only? ☐ YES ☐ NO ☐ N/A

PRIMARY PROVIDER'S PHARMACEUTICAL ORDERING AUTHORIZATION

To comply with the DEA guidelines according to the Code of Federal Regulations part 1301.71 sections (a), for security control on pharmaceutical orders on your behalf, orders will not be processed unless this section is completed.

I,_____ **authorize the following individual(s) to place pharmaceutical orders on my behalf:**
Primary Provider's Name (printed)

Name: _____ *Title:* _____
Name: _____ *Title:* _____
Name: _____ *Title:* _____

I certify that I am solely responsible for any controlled substance ordered, dispensed and returned from my registered Practice. This location dispenses pharmaceuticals within the rules and regulations of governing state authority and the federal DEA and I attest that a valid provider/patient relationship exists. The prescriptions that are dispensed under my authority are for a legitimate medical purpose/diagnosis within the scope of the practitioner's professional practice. The products I purchase through Aidarex, shall not be distributed or sold to anyone for the purpose of resale or for distribution other than to the patient to whom it was prescribed. I do not, nor do any of the individuals noted here, engage in any "Internet-related" activity and are not affiliated with "Internet Pharmacy "activities without having established a valid physician/patient relationship. Furthermore, If any facts here or representations reflected above are changed, Aidarex shall be promptly notified prior to or immediately upon the affected change.

AIDAREX POLICIES, TERMS AND CONDITIONS

ORDER POLICY

- Orders shall be placed for a minimum of 5 bottles per item. Single bottle ordering is not permitted unless otherwise authorized.
- Aidarex will automatically call my account if the only available medication stock has **6 months or less dating** on the label to ensure that it can still be used by the practice before the medication expires. I understand that I have the option to wait for longer expiration dating, but Aidarex cannot guarantee when new, longer-dated stock may become available.

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- If I choose to use the Auto-Ship function in MDScripts, I am electronically authorizing the system to place orders on my behalf. Any order that is shipped that I consider was an "accident" shall not be returned or credited. It is my responsibility to maintain/manage my inventory.

SHIPPING POLICY

- Orders are processed on a "first come, first served" basis unless otherwise stated by Aidarex. Aidarex makes its best effort to process and ship ALL orders that arrive before 12:00pm PST but makes no guarantees.
- Orders that are $150.00 or more will receive FREE UPS Ground shipping. Orders under this amount may incur shipping and handling charges. Expedited shipping requests are at my expense.
- If medication is backordered, Aidarex will ship the backordered product within 48 hours of receipt of additional stock. Backorders are shipped at our standard UPS Ground method unless other terms have been discussed and agreed upon between myself and Aidarex.

RETURN POLICY

- All sales are final. Product may not be returned except in cases of a recall or where there was an error made by Aidarex. Returns must be authorized by Aidarex in the form of a Return Authorization. Any un-authorized returns sent to Aidarex will be returned to sender and may cause additional charges to be applied to my account.

PRICING POLICY

- All pricing provided is CONFIDENTIAL between Aidarex and the party quoted. Under no circumstances is pricing to be distributed without receiving prior authorization from Aidarex. Product pricing and availability is subject to change at any time, without prior notice. Aidarex will make every reasonable effort to notify me when pricing changes to ensure that the medication is still a valid option for my formulary.

INVOICE AND PAYMENT POLICY

- All accounts are set up on **NET 30** terms unless other payment arrangements have been made between myself and Aidarex. Aidarex will not ship orders to past-due accounts. All prices are exclusive of City, State & Federal Taxes. There will be a 1.5% per month (18% Per Annum) charge on balances 30 days past-due. If collections efforts are deemed necessary, purchaser will pay all costs for collection, including court and attorney fees if applicable. The undersigned represents and warrants that he/she has the authority to execute this credit agreement on behalf of the purchaser and that purchaser will be fully responsible to pay for all products sent to purchaser by Aidarex regardless of who is using that product.

By signing this form I agree to abide by all Aidarex policies and attest that all information related to my name, license or Practice noted here is accurate and complete to the best of my knowledge.

Primary Provider Signature: _____ Date: _____