

Return To: IMPLANON / NEXPLANON Customer Support From: _____

Fax: 866.389.7928 Phone: _____

Pages: _____ Date: _____

Memo: _____

The Specialty Distributor of Choice

Thank you for choosing CuraScript for all your women's healthcare needs. Before we complete the account set-up process, please return the following using this provided fax cover sheet. If you have any questions regarding the account set-up process or your ordering options for IMPLANON® / NEXPLANON®, please contact our dedicated IMPLANON® / NEXPLANON® Customer Support team at:

Phone: 866.844.0148

E-Mail: customer.service@curascript.com

Special Pricing Considerations

Check all that apply: PHS/340b Pricing Planned Parenthood Facility HIN No.: _____
 FSS Pricing GPO Affiliation _____

Remember to include: Return Fax Cover Sheet Completed Credit Application Copy of State Medical License
 Copy of DEA License State Credit App or Authorization Hospital Credit App/Credit Packet

Trained Clinicians (Please list all trained clinicians eligible to order on this account)

IMPLANON® / NEXPLANON® Return Policy

CuraScript can authorize return or exchange of IMPLANON® / NEXPLANON® if accompanied by a Return Goods Authorization (RGA) form and with verification that products were stored according to manufacturer specifications. CuraScript reserves the right to determine the eligibility of product to be returned for credit. An RGA form can be obtained by calling the IMPLANON® / NEXPLANON® Customer Support Team at 866.844.0148 or by using www.curascriptonline.com.

Items Eligible for Return

Shipping Errors: Merchandise shipped in error by CuraScript must be reported within 72 hours from date of invoice.

Shortages and Damages: The IMPLANON® / NEXPLANON® Customer Support Team must be notified of any damages or shortages within 72 hours of delivery. CuraScript will arrange pick-up of the damaged product at no cost to you.

Expired and Short-Dated Products: Expired goods must be returned within twelve (12) months after the expiration date, unopened and unused. Short-dated products can be returned within 3 months of expiration date for a full refund.

Product Over-Stock: The IMPLANON® / NEXPLANON® Customer Support Team must be notified within 30 days of receipt for full refund. Product returned within 31-90 days of order date will be refunded less a 15% restocking fee.

Extenuating Circumstances: If you have a return request that involves extenuating circumstances, please contact the IMPLANON® / NEXPLANON® Customer Support Team at 866.844.0148. A 15% restocking fee may apply.

NO CREDIT WILL BE ISSUED FOR MERCHANDISE RETURNED WITHOUT PRIOR AUTHORIZATION FROM CURASCRIPT.

Questions

Contact our dedicated IMPLANON® / NEXPLANON® Customer Support Team at: Phone: 866.844.0148 Fax: 866.389.7928 E-mail: customer.service@curascript.com

IMPLANON® / NEXPLANON® is a registered trademark of Schering-Plough Corporation.

Credit Application



Billing and Shipping Information

Bill To (legal entity name) _____

Legal Address _____

Suite / Bldg / Floor / Mailstop _____

City _____ State _____ Zip _____

Billing Address _____

Suite / Bldg / Floor / Mailstop _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Ship To _____

Shipping Address _____

Suite / Bldg / Floor / Mailstop _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Multiple shipping addresses (please attach a list of additional addresses)

Purchasing Contact _____ PC E-mail Address _____

Accounts Payable Contact _____ AP E-mail Address _____

Company Information

Business Type: Reseller/Distributor Closed Door Rx Open Door Retail Rx Treating Provider/Clinic

Organization Type: Corporation (type) Partnership (type) Sole Proprietor

Payer Mix: (Please enter percentage of each) ___% Medicare ___% Medicaid ___% Self-Pay ___% Other

Name on State License _____ Name on DEA License _____

State License Number (Please attach a copy) _____ Expiration _____

DEA License Number (Please attach a copy) _____ Expiration _____

Federal Tax ID Number/SS# _____ Years in business _____ Est. Avg. CuraScript Purchases (\$) _____

Exempt from Sales/Use Tax: Yes No (Please attached a copy of your Sellers Permit and Resale Certificate)

Any voluntary liens of prior bankruptcies? Yes No (If yes, please provide the date, court & case number)

*Upon review of your application, you may be required to supply copies of your balance sheet, income statement and statement of cash flows.

Vendor and Bank References

Primary Drug Wholesaler _____ Account Number _____ Phone Number _____ Contact _____

Other Supplier _____ Account Number _____ Phone Number _____ Contact _____

Bank Name _____ Branch/Address _____ Checking Account Number _____

Bank Contact _____ Phone Number _____ Loan Account Number _____ Line of Credit Account number _____

*By completing the above information you are authorizing CuraScript SD to conduct a bank reference check.

By signing the below, I certify that I have received, read, understand, and agree to the Terms and Conditions provided to me with, or printed on the reverse side hereof and made part of this application.

Entity _____

Printed Name _____ Title _____

Signature (Must be signed by a Corporate Officer, Partner, Owner or Authorized Agent) _____ Date _____

This application is submitted to Priority Healthcare Distribution Inc. doing business as CuraScript SD Specialty Distribution (hereinafter referred to as CSD) for the purpose of obtaining commercial credit. The undersigned represents and warrants that all information herein is current, correct and complete, and that CSD may rely on such information in deciding to extend or discontinue credit. The undersigned agrees to notify CSD immediately in writing of any change in the foregoing information including, without limitation, any change in the nature of business, ownership, name or location of the business or financial condition of the undersigned. The undersigned agrees to furnish current financial information from time to time as requested by CSD.

The undersigned acknowledges that before any credit purchases can be made, CSD must first approve this application and alternative forms of security may also be required. CSD may limit or discontinue any credit at its sole discretion. The undersigned authorizes CSD and any credit agency or investigatory service engaged by CSD to verify or otherwise investigate any information contained herein, or reference listed, statements, reports or other information obtained with respect to the undersigned from any other source, as CSD deems appropriate. The undersigned agrees to release all persons, companies or corporations using or supplying such information, including CSD, from any claims and/or losses that may result therefrom.

The prices for items purchased by the undersigned from CSD may include discounts or other reductions in price, and/or may be subject to subsequent rebates or other reductions or adjustments. By signing this credit application, the undersigned acknowledges that it must, to the extent required, report or reflect such discounts or reductions on cost reports or claims filed with federal or state health care programs, and the undersigned acknowledges that it should retain all CSD invoices and other documentation of discounts and make such information available to federal or state health care program officials upon request.

The undersigned understands and agrees that participating vendors (e.g., pharmaceutical manufacturers) from which CSD purchases goods may pay an administrative fee to CSD of 3 percent or less of the purchase price of the goods provided by that vendor. The administrative fee pays for services performed by CSD, such as the administration of chargebacks. If the undersigned is a health care "provider of services," which generally means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program (see 42 U.S.C. § 1320a-7b(b)(3)(C)(ii) (citing the definition of "provider of services" at 42 U.S.C. § 1395x(u))), then the undersigned shall designate itself as such in writing to CSD, and CSD shall provide the undersigned with information, at least annually, and to the Secretary of the U.S. Department of Health and Human Services upon request, the amount received from each vendor with respect to purchases made by or on behalf of the undersigned. If you need additional information regarding administrative fees in order to comply with any legal reporting obligations you have, please contact CSD.

The undersigned agrees to pay in a timely manner all debts, accounts and invoices owing to CSD in full accordance with the agreed upon terms of sale as printed on invoices and that the due date for each invoice is the date by which payment must be received at the CSD "remit to" address noted on invoices and statements. The undersigned acknowledges that all statements of account shall be considered true and correct, unless the undersigned contests the accuracy of any such statement within 30 days of the date thereof, by sending a written inquiry to CSD. The undersigned agrees that in the event such debts, accounts or invoices are not paid when due, they will accrue late charges at the rate of eighteen percent (18%) per annum or the maximum rate allowed by law, whichever is the lesser rate. CSD reserves the right to apply any and all past-due moneys however it deems appropriate.

The undersigned agrees that: (1) this agreement shall be deemed fully executed and performed in the State of Florida and shall be governed by and construed in accordance with the laws thereof; (2) in any action, proceeding, or appeal of any matter relating to or arising out of this judgment, the undersigned shall be subject to jurisdiction of the State of Florida and accept venue in Seminole County, Florida; and (3) the undersigned expressly waives any right to a trial by jury. The undersigned agrees to reimburse CSD for any attorney fees, court costs or collection agency fees CSD may incur in its efforts to collect any past-due amounts.

Upon submission of this application to CSD and review by CSD of the same, the undersigned acknowledges that, prior to the extension of credit by CSD to the undersigned, CSD may require that the undersigned obtain a standby letter of credit in favor of CSD and/or a personal guaranty of one or more principals of the undersigned in favor of CSD (examples of each may be provided upon request). In addition to, undersigned may also be required to provide proof of legal entity.

Please complete the name of the entity on behalf of which this credit application is being submitted, print your full name, title/position, date, and sign in your official capacity on behalf of the entity.