ASP CARES

ASP Cares San Antonio 503B
2414 Babcock Rd. Ste. 106
San Antonio, TX 78229
Ph: 1 (888) 412-5929 Fax: 1 (888) 413-1021.

NEW ACCOUNT SETUP FORMS

Please complete attached forms and fax or email to ASP Cares at your convenience.

Packet Checklist:

- ☐ Recurring Credit Card Charge Authorization Form
- ☐ Agreement for Purchase of Compounded Office Use Medication Form
- ☐ Practitioner's Office Contact Information Form
- ☐ Copy of active State License
- ☐ Copy of active DEA License (if ordering controlled substances)

FDA
REGISTERED
503B OUTSOURCING FACILITY

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RECURRING CREDIT CARD CHARGE AUTHORIZATION FORM

I hereby authorize ASP Cares to make recurring charges to the credit card listed below, and, if necessary, initiate adjustments for any transactions credited/debited in error. This authorization will remain in effect until ASP Cares is notified in writing to cancel it. ASP Cares will bill on the date of shipment unless other terms have been agreed upon.

Facility Name: _____

Practitioner Name: _____

License #: _____

NPI #: _____

DEA #: _____

Address: _____

Phone:_____ Fax:_____

Email Address: _____

Card Type: ☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **Amex**

Name on Card:_____

Card Number:_____

CW Code:_____ Expiration Date:_____

Billing Address:_____

Card-holder Signature:_____ Date:_____

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AGREEMENT FOR PURCHASE OF COMPOUNDED OFFICE USE MEDICATION

The practitioner agrees to purchase compounded medications for office use from ASP Cares under the following guidelines:

1. The compounded drug may only be administered to the patient and may not be dispensed to the patient or sold to any other person or entity.
2. The practitioner shall include on the patient's chart, medication order, or medication administration record the lot number and the beyond-use-date of any compounded drug administered to the patient that was provided by the pharmacy.
3. The practitioner will provide notification to the patient for the reporting of any adverse reaction or complaint in order to facilitate any recall of batches of compounded drugs.

Practitioner Name: _____

License #: _____

NPI #: _____

DEA #: _____

Address: _____

City, State, Zip:_____

Phone:_____

Address: _____

Signature: _____ Date:_____

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PRACTITIONER'S OFFICE CONTACT INFORMATION

Date:_____

Practitioner Name:_____

Facility Name:_____

Office Manager:_____

Physical Address:_____

Office Ph:_____ Office Fax:_____

Email Address:_____

Practitioner Statement Regarding Office Visit Requirements:

In order to ensure that all orders received by ASP Cares are pursuant to a valid practitioner/patient relationship, we require that our practitioners agree that the following elements are satisfied prior to sending an order. The existence of these elements is an indication that a legitimate practitioner/patient relationship has been established:

- A patient has a medical complaint
- A medical history has been taken
- A physical examination has been performed
- Some logical connection exists between the medical complaint, the medical history, the physical examination, and the drug ordered
- All medication ordered as "office use" will come clearly marked as "office use" and "not for resale". These medications are provided for the practitioner to administer to the patient in the office ONLY.

I, _____ , agree that all orders sent to ASP Cares meet the criteria above. I agree that there is no other agreement written, oral, or otherwise that negates this one.

Practitioner Signature:_____ Date:_____