

PARTICIPATION AGREEMENT

INSTRUCTIONS

1. Please complete the information below and on the Pharmacy Demographics Sheet.
2. SIGN, DATE and return a copy of the agreement to UPN, Inc., 801 North Brand Boulevard, Suite 330, Glendale, CA 91203.
3. Please be sure to include current copies of: Pharmacy License, DEA License, Pharmacist in Charge License and Liability Insurance for the pharmacy.

Pharmacy Name _____

Address _____

City _____ State _____ Zip _____

THIS AGREEMENT between the pharmacy identified above (Participating Pharmacy) and United Pharmacists Network, a California corporation (“UPN, Inc.”), provides as follows:

RECITALS

A. UPN, Inc., a California corporation, is operated for the purpose of facilitating commercial transactions between community pharmacies and purchasers of health related services such as health insurance companies, employee benefit programs, etc.;

B. UPN, Inc., intends to enroll individual community pharmacies which can provide Pharmaceutical Services, as defined below, to the patient-beneficiaries of various health care programs;

C. Participating Pharmacy is licensed under the laws of the State of California to provide pharmaceutical products and services to patients;

D. Participating Pharmacy is certified in accordance with the regulations governing participation of providers in the Medical Assistance Program under Title XIX of the Social Security Act (Medicaid).

1. The following definitions apply to this agreement:

1.1 Third party Payer. Any entity which purchases or reimburses the purchase of medical and pharmaceutical products and services on behalf of patient-beneficiaries. Such entities include, but are not limited to, insurance companies, union trusts, employers, medical care foundations, governmental agencies and preferred provider organizations.

1.2 Pharmaceutical Services. The provision of drugs and professional services by Participating Pharmacy to patient-beneficiaries enrolled in Third Party Payer programs in accordance with all applicable state and

federal laws and the Standards of Practice and the Code of Ethics of the pharmacy profession, both as adopted (and from time to time amended) by the California Pharmacists Association.

1.3 Contract Offer. An offer of a Third Party Payer to purchase, on specified terms, Pharmaceutical Services of behalf of eligible patient-beneficiaries.

1.4 Contract. Any agreement reached between Participating Pharmacy and a Third Party Payer as provided herein.

1.5 Usual and Customary Charges. Those amounts which Participating Pharmacy normally charges its regular private patients for the comparable Pharmaceutical Services as may be provided to patient-beneficiaries of a Third Party Payer as provided herein.

2. Contract Offers.

2.1 UPN, Inc. Responsibility. UPN, Inc. shall solicit Contract Offers from the Third Party Payers to purchase Pharmaceutical Services (on behalf of their patient-beneficiaries) from individual community pharmacies which participate in UPN, Inc..

2.2 Terms and Form of Contract Offer. The terms and form of all Contract Offers shall be determined by the Third Party Payers.

2.3 Acceptance of Rejection. Upon receipt from a Third Party Payer, UPN, Inc. will promptly communicate a Contract Offer to Participation Pharmacy for acceptance or rejection. It is understood that acceptance will obligate Participating Pharmacy to provide Pharmaceutical Services in accordance with the terms of the Contract Offer. Participating Pharmacy agrees to accept or reject the Contract Offer within the period specified in the Contract Offer; failure to respond within this specified period shall be deemed a rejection or an acceptance as specified in the Contract Offer.

2.4 Participating Pharmacy Not Obligated to Accept. It is understood that Participating Pharmacy is not obligated to accept any specific Contract Offer or any minimum number of Contract Offers.

3. Drug Utilization Review Program (DUR). Participation Pharmacy agrees that UPN, Inc. may offer to Third Party Payers, in conjunction with any Contract entered into between Participation Pharmacy and a Third Party Payer, a drug utilization review program. Participation Pharmacy agrees to cooperate with UPN, Inc. to assure through such DUR Program the appropriateness of Pharmaceutical Services provided to patient-beneficiaries.

4. Claims Processing. Participating Pharmacy agrees that UPN, Inc. may provide to Third Party Payers, in conjunction with any Contract Offer accepted by Participating Pharmacy, a service for the processing and administration of claims for payment. Although claims for payment may be submitted to UPN, Inc., Participating Pharmacy agrees that all liability for payments to Participating Pharmacy under the terms of any Contract shall remain with Third Party Payer until payment is made to UPN, Inc., and that Participating Pharmacy also agrees to provide UPN, Inc. access to its prescription records and books of accounts, on reasonable notice, to verify the accuracy of any claims submitted for payment and to verify compliance with a Contract.

5. Participation Fees. Participating Pharmacy agrees to pay an initial non-refundable enrollment fee to be established by the Board of Directors. Subject to the termination provision of paragraph 8.3 below, Participating Pharmacy may be assessed additional fees where UPN, Inc. deems such fees necessary.

6. Resolution of Disputes.

6.1 Disputes Between Participating Pharmacy and Third Party Payer. In the event of a dispute between Participating Pharmacy and a Third Party Payer arising out of any Contract created hereunder, Participating Pharmacy agrees to submit the dispute to binding arbitration under the rules of the American Arbitration Association.

6.2 Disputes Between Participating Pharmacy and UPN, Inc. In the event of a dispute between UPN, Inc. and Participating Pharmacy (other than one covered by paragraph 6.1 above), Participating Pharmacy and UPN, Inc. agree to meet and confer in good faith to resolve the dispute. If the dispute is not resolved through such meetings, the parties agree to submit the dispute to binding arbitration under the rules of the American Arbitration Association. In the event of such a dispute, Participating Pharmacy agrees to continue to perform all Pharmaceutical Services and to otherwise discharge its obligations under the terms of any all Contracts with Third Party Payers.

7. Transfer of Ownership. Participating Pharmacy agrees, in the event of a sale or transfer of a substantial part of its shares or assets, to notify the purchaser of this Agreement and all Contracts between Participating Pharmacy and Third Party Payers and to make such sale or transfer contingent upon an agreement by the purchaser to be bound by the terms thereof. Prompt written notice of any such sale or transfer shall be given to UPN, Inc. Failure on the part of any purchaser to accept and be bound by the terms of this Agreement may result in immediate termination hereof, but without prejudice to any rights or remedies of UPN, Inc. or any Third Party Payer under any non-expired Contract to which Participating Pharmacy shall remain bound. At the time notice of a sale or transfer is given to UPN, Inc., Participating Pharmacy shall also provide to UPN, Inc. information reasonably requested by UPN, Inc. concerning purchaser.

8. Miscellaneous.

8.1 Indemnity. Participating Pharmacy agrees to indemnify and hold UPN, Inc. harmless from any loss, cost of liability (including litigation costs and attorney's fees) arising out of the performance of the breach of any obligation entered into by Participating Pharmacy with a Third Party Payer under the terms of any Contract, or otherwise arising from the acts, conduct or omissions of Participating Pharmacy, its employees, agents or representatives.

8.2 Insurance. Participating Pharmacy shall maintain and keep in force during the term of this Agreement and any Contract entered into with a Third Party Payer hereunder, insurance covering professional malpractice liability, with minimum coverage of \$1,000,000 per incidence per year and an aggregate total of \$2,000,000 of such insurance in the form of policies or certificates, and proof of such insurance shall be furnished to UPN, Inc. within 30 days upon request.

8.3 Term and Termination. This agreement shall become effective on the date it is executed by Participating Pharmacy and shall remain in effect until terminated by either party as set forth in this paragraph. This Agreement may be terminated by either party upon written notice, sent certified mail to the other, provided that the obligations of Participating Pharmacy under any Contract with a Third Party Payer shall remain in full force and effect until expiration of such Contract.

8.4 Non-exclusive Agreement. Participating Pharmacy reserves the right to participate in other prescription programs provided that its ability to perform obligation entered into with any Third Party Payer hereunder shall not be impaired.

8.5 Maintenance of Certification. Participating Pharmacy agrees, during the term of this Agreement and any Contract entered into with a Third Party Payer, that it shall maintain its license under the laws of the

State of California and its certification as a provider in accordance with the regulation governing participation of providers in the Medical Assistance Program under Title XIX of the Social Security Act (Medicaid).

8.6 Notices. All notices to either party hereunder shall be in writing and sent by first class mail to the other party at the address shown in this Agreement or as the same may be changed by written notice.

8.7 Advertising. During the term of this Agreement, Participating Pharmacy may represent to the public that it is a Participating Pharmacy hereunder, but use of the words, symbols, trademarks or service marks which are the property of UPN, Inc. in advertising, promotional materials or otherwise shall be subject to the written approval of UPN, Inc. All such representations and promotions shall cease immediately upon termination of this Agreement. Participating Pharmacy agrees that UPN, Inc. may use its name, address and telephone number in rosters, directories or lists of participating pharmacies.

PARTICIPATING PHARMACY

UNITED PHARMACISTS NETWORK, INC.

By: _____

By: _____

Date: _____

Date: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

IMPORTANT

UNITED PHARMACISTS NETWORK, INC. Pharmacy Demographics Sheet

Please type or print neatly

Name of Pharmacy: _____

Address: _____

City: _____ State: _____ Zip code: _____

Owner(s) name(s): _____

Contact person: _____

Phone number: (_____) _____ Fax number: (_____) _____

NCPDP: _____ NPI#: _____

Federal Tax Id Number: _____ Medi-Cal #: _____

Pharmacy Email Address: _____

Primary wholesaler: _____ Secondary wholesaler: _____

Pharmacy hours: Monday – Friday _____ Saturday _____

Sunday _____ Holidays _____

Languages spoken other than English: Chinese Vietnamese Russian Cambodian
 Armenian Spanish Korean
 Other _____

Delivery service available? Yes No If yes, what is charged? _____

Does your pharmacy specialize in: Allergy DME Sports Medicine
 Compounding DM Seniors HIV/AIDS
 Ethnic Populations _____
 Other _____

Does your pharmacy have a consultation area? Yes No

If yes, is it a private area? Yes No

Pharmacy system: _____

Electronic claims switching service bureau: Envoy NDC GGC
 Other _____



The National Council for Prescription Drug Programs (NCPDP) maintains the NCPDP Pharmacy Database, which contains information on pharmacy demographics, hours of operation, licensing information, pharmacy payment center information and other relationships and affiliations including your relationships with other entities. Industry uses this database for claims processing, direct mailings of product recalls and publications, network development, health plan directories and rebate information.

The lack of a standardized form has led to confusion and ultimately, to the occasional disruption of proper payment and claims processing at the pharmacy level. Therefore, NCPDP has developed a universal relationship form for PSAO's in order to standardize the industry.

Form Information

Please complete *all* sections of the form. **Bold and underlined** fields are required, and the form *will not* be processed if *any* required field is left blank. Forms must be received within 30 days of the signature date on the form in order to be processed.

Section 1 requires information about the pharmacy. All **bold and underlined** fields are required to process the form.

- Section 2 is for establishing and reporting active relationships. All active Chain, Franchise or Third Party relationships should be listed, as well as any relationships that you are beginning. If you establish a new, exclusive Third Party relationship in this section, any Third Party affiliations you had for the same taxonomy codes prior to this establishment will be terminated. If you are unsure of your relationship, payment center or taxonomy codes, please contact your PSAO directly or contact NCPDP's Provider Services Department at (480) 477-1000.
- Section 3 is for ending relationships. Any and all relationships that are no longer active should be listed. If you are establishing a new, exclusive Third Party Relationship, please list any terminating relationships you had prior to the new exclusive Third Party relationship for the same taxonomy code in order to terminate them. If you are unsure of your relationship, payment center or relationship codes, please contact your PSAO directly or contact NCPDP's Provider Services Department at (480) 477-1000.
- Section 4 is the Authorization section. The *signature* of your pharmacy's authorized representative and the *date* are required in order for the form to be processed. The date in this section must be *within 30 days* of the received date for NCPDP to process the form.

If you have any questions regarding this form, please contact NCPDP's Provider Services Department at (480) 477-1000.

This Affidavit is to affirm my pharmacy's affiliation relationship(s) as documented below.
 I understand my pharmacy's relationships will be updated on the National Council for Prescription Drug Programs (NCPDP) Database if received by NCPDP within 30 days of the signature date on this form and will be based on the Effective Date(s) indicated below. This Affidavit must be received by NCPDP before 15th of the month to assure inclusion in the following month's NCPDP v2.x file distribution.

*All fields in **bold and underlined** font must be filled out in order for form to be processed.*

SECTION 1 – PHARMACY INFORMATION:

<p><u>Pharmacy NCPDP Number:</u> _____ Pharmacy _____ Legal Name: _____</p> <p><u>Physical Address:</u> _____</p> <p><u>City:</u> _____ <u>State:</u> _____ <u>Zip:</u> _____</p> <p><u>Pharmacy Phone:</u> _____ <u>Pharmacy Fax:</u> _____ Phcy. E-Mail _____ Address: _____</p> <p><u>State Board License:</u> _____ <u>DEA Number:</u> _____</p> <p><u>Federal Tax ID:</u> _____ <u>Medicare ID:</u> _____</p> <p>Medicaid ID: _____</p> <p><u>Primary Contact's Name:</u> _____ <u>Email:</u> _____ <u>Title (PIC, Mgr, Owner):</u> _____ <u>Phone:</u> _____</p>	<p>Organizational (Phcy) NPI Number: _____</p> <p><u>Pharmacy</u> _____ <u>DBA Name:</u> _____</p>
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SECTION 2 - ADDITION/ACTIVE RELATIONSHIP AFFILIATIONS:

Please list all active chain, franchise or third party relationships in the following table. The addition of an *exclusive* Type 5 – Third Party Contracting Relationship will automatically terminate any existing Type 5 Third Party Contracting Relationships as of the new start date.

<p>Primary Relationship Name: _____</p> <p>Primary Relationship Code: *</p> <p>Relationship Type: <input type="checkbox"/> Chain <input type="checkbox"/> Franchise <input type="checkbox"/> Buying Group <input type="checkbox"/> 3rd Party Reconciliation <input type="checkbox"/> 3rd Party Contracting</p>	<p>Exclusive: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Payment Center Code*:</p> <p>Related Taxonomy Code*:</p> <p>Effective Date of Affiliation: _____</p>
<p>Additional Relationship Name: _____</p> <p>Additional Relationship Code: *</p> <p>Relationship Type: <input type="checkbox"/> Chain <input type="checkbox"/> Franchise <input type="checkbox"/> Buying Group <input type="checkbox"/> 3rd Party Reconciliation <input type="checkbox"/> 3rd Party Contracting</p>	<p>Exclusive: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Payment Center Code:</p> <p>Related Taxonomy Code:</p> <p>Effective Date of Affiliation: _____</p>
<p>Additional Relationship Name: _____</p> <p>Additional Relationship Code: *</p> <p>Relationship Type: <input type="checkbox"/> Chain <input type="checkbox"/> Franchise <input type="checkbox"/> Buying Group <input type="checkbox"/> 3rd Party Reconciliation <input type="checkbox"/> 3rd Party Contracting</p>	<p>Exclusive: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Payment Center Code:</p> <p>Related Taxonomy Code:</p> <p>Effective Date of Affiliation: _____</p>

SECTION 3 - TERMINATION (ENDING) RELATIONSHIP AFFILIATIONS:

Please end any and all relationships that are no longer active or will be ending in the near future. If you are adding your pharmacy to an exclusive relationship, please use this section to end all other relationships.

Primary Relationship Name: Primary Relationship Code: * Relationship Type: <input type="checkbox"/> Chain <input type="checkbox"/> Franchise <input type="checkbox"/> Buying Group <input type="checkbox"/> 3 rd Party Reconciliation <input type="checkbox"/> 3 rd Party Contracting	Exclusive: <input type="checkbox"/> Yes <input type="checkbox"/> No Payment Center Code: * Related Taxonomy Code: * Termination Date of Affiliation:
Additional Relationship Name: Relationship Code: Relationship Type: <input type="checkbox"/> Chain <input type="checkbox"/> Franchise <input type="checkbox"/> Buying Group <input type="checkbox"/> 3 rd Party Reconciliation <input type="checkbox"/> 3 rd Party Contracting	Exclusive: <input type="checkbox"/> Yes <input type="checkbox"/> No Payment Center Code: Related Taxonomy Code: Termination Date of Affiliation:
Additional Relationship Name: Relationship Code: Relationship Type: <input type="checkbox"/> Chain <input type="checkbox"/> Franchise <input type="checkbox"/> Buying Group <input type="checkbox"/> 3 rd Party Reconciliation <input type="checkbox"/> 3 rd Party Contracting	Exclusive: <input type="checkbox"/> Yes <input type="checkbox"/> No Payment Center Code: Related Taxonomy Code: Termination Date of Affiliation:

***This affidavit cannot be processed by NCPDP if the relationship and related taxonomy codes are not provided. Taxonomy Codes can be found at <http://www.wpc-edi.com/taxonomy>.**

***Relationship Codes are 3-digits. Payment Center Codes are 6-digits. If you are uncertain of your Relationship or Payment Center Codes, please contact your relationship provider (PSAO) or NCPDP Provider Services Department at (480) 477-1000.**

SECTION 4 – AUTHORIZATION TO PROCESS:

Signature: _____
(Signature of contact from Page 1)

Date: _____

Name _____
(Print or type Name and Title)

Title: _____

Note: This affidavit must be received by NCPDP within 30 days of the date signed above in order to be processed.





Purchasing Group Designation

Company Legal Name _____
 DBA Name (if different) _____
 Street Address _____
 City, ST, Zip _____ Phone _____
 State License # _____
 DEA # _____

Anda, Inc. / VIP, Inc.
 Division of Watson Pharmaceuticals, Inc.

_____ (Customer) is a current member of, and hereby designates _____ as the Customer's purchasing organization and is therefore entitled to receive any membership benefits that have been agreed upon with Anda/VIP under this primary designation.

Effective date of purchasing group membership _____

Please select Customer's primary class of Trade:

- | | |
|--|--|
| <input type="checkbox"/> Clinic | <input type="checkbox"/> Hospice |
| <input type="checkbox"/> Physicians | <input type="checkbox"/> Hospital- In-Patient |
| <input type="checkbox"/> Government- Federal | <input type="checkbox"/> Senior Living |
| <input type="checkbox"/> Mail Order | <input type="checkbox"/> Hospital- Out-Patient |
| <input type="checkbox"/> Government- State | <input type="checkbox"/> Specialty/Infusion |
| <input type="checkbox"/> Repackager | <input type="checkbox"/> LTC Pharmacy |
| <input type="checkbox"/> Student Health | <input type="checkbox"/> Retail |
| <input type="checkbox"/> Chain-Non-Warehousing | <input type="checkbox"/> Chain-Warehousing |

Is Customer considered a closed door or alternate care pharmacy? Y___ N___

In order to qualify for special pricing from Anda/VIP, it is understood that Customer does not sell to conventional retail customers. Customer agrees to meet this requirement and will forfeit special pricing from Anda/VIP if Customer does not comply. If Customer has a change to their closed door or alternate care pharmacy status, notification will be sent to Anda/VIP in writing within 30 days.

Monthly Volume _____ bed or script count _____

Confidentiality Agreement

All information relating to the respective business and financial affairs of the customer and Anda/VIP, including but not limited to pricing and discounts, shall be kept in strict confidence by the other party hereto. The foregoing obligation does not apply to any information that has become publicly available, that is rightfully obtained from third parties who are not bound by any confidentiality requirement, or disclosures, which are required to be made under any state or federal law.

This designation shall supersede any and all previously executed Agreements with Anda/VIP, Inc. with respect to the subject matter hereof. Customer is permitted to change purchasing organization designation one time per quarter upon 30 days written notice to Anda/VIP

 Customer Signature
 Printed Name _____
 Title _____
 Date _____

Please fax signed form to (954) 217-4138

The Harvard Drug Group, L.L.C.
d/b/a Major Pharmaceuticals / Letco Medical / Expert Med

Credit Application

Acct # _____

Legal Name of Business: _____ **d/b/a** _____

Ship to Address: _____ City: _____ State: _____ ZIP: _____

Bill to Address: _____ City: _____ State: _____ ZIP: _____

Business Phone: _____ Fax: _____ E-mail: _____

Should we charge sales tax? Yes No (If No, give Tax I.D. Number & attach copy of Sales Tax Certificate) Tax I.D.: _____

Accounts Payable Manager: _____ Buyer's Name _____

Payment Option: ACH Draft; to be drafted on due date.

Send my Statements via: No Statement (pay by invoice) E-Mail Fax Have You Ever Filed for Bankruptcy? Yes No

Ownership: Sole Proprietor Partnership Corporation LLC; Years in Business: _____ **DUNS #:** _____ - _____ - _____

Owner: Name _____ SS # _____ - _____ - _____

Home Address _____ City _____ State _____ ZIP _____ Home Phone _____ - _____ - _____

Previous Account: No Yes If Yes, Account # _____

Bank Reference: Name of Bank: _____ Type of Account: _____

Banker: _____ Phone: _____ - _____ - _____ Account #: _____

Trade References: Please list primary wholesaler on line one.
NAME ADDRESS/CITY/STATE/ZIP ACCT # TELEPHONE #

1. _____ (_____) _____

2. _____ (_____) _____

3. _____ (_____) _____

The undersigned agrees to pay service charges of 1.5% per month or the highest lawful rate, whichever is lower on any past due balance, and all actual attorney fees and costs of collection; bank draft of account when account becomes delinquent.

I, _____ personally guarantee all payments of existing and future obligations and
(Print Name)

unconditionally waive the right to any amount paid pursuant to this provision. The undersigned also agrees to jurisdiction and venue in Michigan. The above statements are made for purposes of procuring credit from The Harvard Drug Group and its divisions and affiliates including Major Pharmaceuticals, Letco Medical and Expert Med ("company"). The undersigned hereby consents to the confirmation by company, of the information contained herein and authorizes company to contact the undersigned's bank and all credit references and obtain any necessary credit reports.

Terms of sale have been fully explained and I understand that if an account is established, my credit line is subject to periodic review. Also shipments may be held if my account is delinquent or exceeds my established line of credit. The undersigned further represents that its professional licenses are in good standing and not the subject of any proceedings by any governmental agency and agrees to notify the seller immediately upon the commencement of any such proceedings. The undersigned authorizes company to take appropriate measures in verifying the credit of the undersigned and releases company from any obligation while researching this information. Customer and Guarantor agree to provide company with 60 days notice of its intention to sell all of its assets. Special contract pricing is subject to verification of entitlement at any time after the sale and customer agrees to refund in the event there is no entitlement.

Signature of Guarantor: _____

_____ **Date**

Print Name: _____

PLEASE INCLUDE A COPY OF YOUR STATE BOARD AND DEA LICENSE AND SALE TAX EXEMPT (if applicable)

Calls to and from The Harvard Drug Group, its divisions and affiliates, may be monitored for quality assurance purposes. The Harvard Drug Group LLC, its divisions and affiliates, may from time to time, provide promotional information via phone, fax or e-mail to its customers. You may request to be removed from any of these channels by calling 1-800-875-0123 Ext. 2000 or you may send an e-mail to opt-out@harvarddruggroup.com

The Federal Equal Credit Opportunity Act prohibits creditors from discriminating against credit applicants on the basis of race, color, religion, national origin, sex, marital status, age; (provided the applicant has the capacity to enter into a binding contract); because all or part of the applicant's income derives from any public assistance program; or because the applicant has in good faith exercised any right under the Consumer Credit Protection Act. The federal agency that administers compliance with this law concerning this creditor is Federal Trade Commission, Equal Credit Opportunity, Washington, D.C. 20580. Revised 7/07/09