

CUSTOMER ALTERNATE CARE ACCEPTANCE FORM

The undersigned customer does hereby certify that it is a (profit) or (non-profit) organization that maintains a closed-door pharmacy (*no retail affiliation or sales to the general public*) and that the products purchased under the Customer Pharmacy Supplier Agreement with AstraZeneca at favorable prices are for its "own use", and no products purchased hereunder may be commercially resold or redistributed to any other entity or person. Sales and/or redistribution of said products to any other type of entity, account or third party will be a violation of such Agreement and in addition to pursuing any other remedies that AstraZeneca may have available at law or equity, AstraZeneca terminates your right to receive products and/or reimbursements under said Agreement. The undersigned agrees to permit AstraZeneca to at least annually audit, on reasonable notice and during normal business hours, the relevant books and records of the undersigned. Furthermore, the undersigned certifies that products purchased will be used in accordance with the prescription information. The undersigned further certifies that all data submitted by them to the exclusive GPO of choice or to AstraZeneca for chargebacks and other reimbursements relating to purchases by Facility under the AstraZeneca contract with the exclusive GPO of choice must be data originating from purchases of U.S. AstraZeneca product bearing an AstraZeneca 11-digit National Drug Code, as assigned by the United States Food and Drug Administration. In addition, all applicable federal and state laws must be adhered to. The undersigned also certifies that Facility's pharmacy(ies) that dispense(s) AstraZeneca products which are the subject of the Agreement between AstraZeneca and the exclusive GPO of choice are located, licensed and registered within the United States of America;

Please check the box which best describes your facility:

- | | |
|--|--|
| <input type="checkbox"/> Clinic | <input type="checkbox"/> Oncology Center |
| <input type="checkbox"/> Home Health/Home Infusion | <input type="checkbox"/> Physician/Practitioner |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Surgery Center/Freestanding Surgical Facility |
| <input type="checkbox"/> Rehabilitation Facility | <input type="checkbox"/> HMO Facility |
| <input type="checkbox"/> Long Term Care Facility (Nursing Home/Nursing Home Provider) | |
| Nursing Home Provider – Sales of products purchased are limited to licensed nursing homes, approved correctional facilities and other long-term care facilities for their own use. | |
| <input type="checkbox"/> Other (if checked, please explain on the line below) | |

(Customer Name)

(Address)

(City, State, Zip)

(Printed Name of Director of Pharmacy)

(Authorized Signature of Director of Pharmacy)

(Date of Signature)

(DEA Number)

(HIN Number)

(Designated Wholesaler)

(website address if applicable)

**Please return completed form to: Contract Operations Membership Department
AstraZeneca, 1800 Concord Pike, Rollins Bldg.
Wilmington, DE 19850
Fax: (302) 886-4338**

PLEASE NOTE: All Facilities are subject to the approval of AstraZeneca