

**A CUSTOMER AND SHIPPING INFORMATION**

Facility Name: \_\_\_\_\_ Account # \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
 Company Shipping Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

**B ITEM CERTIFICATION**

**We certify that the items purchased will be used only by the organization named above. The material will not be sold to a third party, distributed or used for any other purpose. Prescription Drugs are subject to the U.S. Federal Export Control Regulations and may not be exported or otherwise removed from the U.S. without prior written authorization from the U.S. Department of State. [Please check box]**

**C PRODUCT CATEGORY AND LICENSE INFORMATION**

**I, the undersigned, am the Medical Director or Pharmacist-in-Charge for the above-named facility at the above-specified shipping address. In this capacity, I hereby authorize the facility to authorize the below-indicated category(ies) of products and submit the following referenced license(s) with respect to such orders, with a copy of such license(s) attached to this form.** [Please check appropriate box(es) and complete corresponding license information.]

- I wish to order Unlimited Prescription Drugs and/or Medical Devices or
- I wish to order Limited Prescription Drugs and/or Medical Devices, please list:

\_\_\_\_\_

Practitioner's License or State Board of Pharmacy License # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

DEA License # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Prescription medications or prescription devices purchased must be shipped specifically to shipping address associated with the license. Please provide either medical director, pharmacists-in-charge or Authorized practitioner license that corresponds to desired shipping location.

I hereby swear under penalty of perjury that (i) I am the (check one):  Practitioner  Director  Pharmacist-in-Charge with responsibility for the facility identified above in Part A with respect to the specified address; (ii) that the license information provided is current and accurate and I am, therefore, licensed to authorize shipment of the substances indicated on this form to the facility designated.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Print Title: \_\_\_\_\_

Authorized Practitioner's Email: \_\_\_\_\_ Authorized Practitioner's Phone: \_\_\_\_\_

**Instructions:**

*This Authorization is only valid if accompanied by a copy of the license specified in Part C. This Authorization will expire at the time of the expiration of the above-specified license (as applicable to the product ordered). Upon expiration, a new Authorization must be submitted for orders to be processed. If there is a change in Medical Director or Pharmacist-in-Charge, this Authorization will immediately become invalid and a new Authorization, including applicable license(s), must be submitted for orders to be processed.*

*Please complete this form and submit a copy of the appropriate license to Customer Licensing by email to [Customerservice@lexiconsupply.com](mailto:Customerservice@lexiconsupply.com) or by mail to 4757 E Speedway Blvd # 110, Tucson, AZ 85712. Please call for questions or assistance with this form (520) 623-3830*