Customer Service

Customer Service is our goal at Auburn Pharmaceutical. Our experienced Account Managers are customer service oriented and very knowledgeable. They will keep you informed with the latest industry news such as products, pricing information and shortages. Our Account Managers are readily available via telephone call, fax request, or email. Customer Service is our priority. Enjoy the Difference!

Call 1-800-222-5609
Visit us online at www.AuburnGenerics.com for 24 Hour Online Ordering
Email: customerservice@auburnpharm.com

Troy, Michigan Main Office
HOURS OF OPERATION
Monday- Friday (8:30am-6:30pm EST)
Fax #: 248-526-3750

Address
2354 Bellingham
Troy, MI 48083

Salt Lake City, Utah Warehouse
HOURS OF OPERATION
Monday- Friday (8:30am-6:00pm MTN)
Fax #: 801-886-1526

Remit Address
P.O. Box 72216
Cleveland, OH 44192-2216

RETURN POLICY

All returns must receive prior authorization. For full credit the return must be made within 90 days from purchase date. The price paid or current price, whichever is lower, plus a 25% restocking fee, will be credited after 90 days. Only products and lot numbers purchased from Auburn Pharmaceutical may be returned for credit. Contact your Account Manager or our customer service department at 800-222-5609 for a return authorization.

Only unopened merchandise will be eligible for a return credit. Items marked as *NR* are not returnable. Expired product is not returnable. No credit will be issued for opened or partial bottles unless product is recalled. Please remove all price stickers and other markings from products. Defaced, damaged or soiled products are subject to a 25% restocking charge. Return requests over $1,000.00 are subject to special review and may be subject to handling fees.

Enjoy the Difference

How to Start Your Savings...

1. Fill out and fax the completed
"Confidential Credit Agreement " to 248-526-3713
along with:
Copy of the Owners/Guarantors Drivers License
Copy of Sales Tax Exemption Certificate

2. Fill out and fax the completed
"Customer Compliance Questionnaire" to:
248-247-3272 or email to: Compliance@auburnpharm.com
Copy of your DEA License,
Copy of your State License,
Copy of your Controlled Substance License
(Where Required by Law)

3. An Auburn Pharmaceutical Account Manager will contact you within one business day

Enjoy the Difference

Auburn Pharmaceutical
2354 Bellingham, Troy MI 48098
800-222-5609
www.AuburnGenerics.com

Confidential Credit Agreement

Company Name _____ ☐ Multiple Locations or Pharmacies

DBA _____

Date of Current Ownership _____

Phone Number _____

T3 email: _____

Federal ID # _____ NABP # _____

☐ Corporation ☐ Single Owner ☐ Partnership

Owner/Officer Name _____

Office Manager/Accounts Payable _____

Accounts Payable Email Address _____

Accounts Payable Telephone #: _____

Accounts Payable Fax #: _____

All invoices are due by the 10th of each month and will be for purchases from the previous month. No alterations of payment conditions will be acknowledged unless approved by Auburn Pharmaceutical. All past due accounts over 30 days will be assessed 1.5% finance charge each month. In case of default, all reasonable collection and/or attorney fees will be assessed. The undersigned also agrees to jurisdiction and venue in Michigan.

Terms of sale have been fully explained and it is understood that if the account is established, the credit line is subject to periodic review. Also shipments may be held if the account is delinquent or exceeds the 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. Customer and Guarantor agree to provide company with 60 days notice of its intention to sell all of its assets.

All information stated above is correct to the best of your knowledge and you give permission for Auburn Pharmaceutical to verify any or all of this information and for all parties to release credit information to Auburn Pharmaceutical.

By signing the credit agreement you acknowledge responsibility for payment by both the corporation, if any, and yourself individually.

_____ _____
Signature Company Grantor/Owner Grantor Title

_____ _____
Print Name Date

2354 Bellingham, Troy, Michigan 48083 • 800-222-5609 • FAX 248-526-3713 • E-mail address: accounting@auburnpharm.com

Rev. 03/10/21

UNIFORM SALES & USE TAX RESALE CERTIFICATE -- MULTIJURISDICTION

The below-listed states have indicated that this certificate is acceptable as a resale/exemption certificate for sales/use tax. (Full instructions at www.auburngenerics.com) The issuing Buyer and the recipient Seller have the responsibility to determine the proper use of this certificate under applicable laws in each state, as these may change from time to time.

Issued to Seller: AUBURN PHARMACEUTICAL COMPANY
Address: 2360 Bellingham, Troy, MI 48083 &
1979 South 4130 West, Suite A, Salt Lake City, UT 84104

I certify that:
Name of Pharmacy: _____
Address: _____

is engaged or is registered as a

____	Wholesaler
XX	Retailer
____	Manufacturer
____	Seller
____	Other (Specify) _____

and is registered for sales/use tax with the below-listed states and cities within which Seller would deliver purchases to Buyer and that any such purchases are for wholesale, resale, or ingredients or components of a new product or service to be resold, leased, or rented in the normal course of business. Buyer is in the business of wholesaling, retailing, manufacturing, leasing (renting), or selling the following:

Description of Business: _____

General description of tangible property or taxable services to be purchased from the Seller: PHARMACEUTICALS

You MUST enter your Sales Tax # to the right of your State abbreviation

State	Pharmacy's Sales Tax #	State	Pharmacy's Sales Tax #
AL		**NE**	
AR		**NJ**	
AZ		**NM**	
CA		**NC**	
CO		**ND**	
CT		**OH**	
FL		**OK**	
GA		**PA**	
ID		**RI**	
IL		**SC**	
IA		**SD**	
KS		**TN**	
KY		**TX**	
ME		**UT**	
MD		**VT**	
MI		**WA**	
MN		**WI**	
MO			

I further certify that if any property or service so purchased tax-free is used or consumed by Buyer so as to make it subject to sales/use tax, Buyer will pay the tax due directly to the proper taxing authority when sate law so provides or inform the Seller for added tax billing. This certificate shall be a part of each order that Buyer may hereafter give to Seller, unless otherwise specified, and shall be valid until canceled by Buyer in writing or revoked by the city or state. If your State is not listed, you are not required to submit this form.

Under penalties of perjury, I swear or affirm that the information on this form is true and correct as to every material matter.

Authorized Signature: _____
(Owner, Partner, or Corporate Officer, or other authorized signer of Buyer)

Title: _____ Date: _____

CUSTOMER COMPLIANCE QUESTIONNAIRE

Account Name: _____ DBA: _____

Address: _____ City, ST, Zip _____

Account Number: _____ DEA Number: _____

Hours of Operation: Monday-Friday _____ Saturday_____ Sunday_____

Business Type: ❑ Retail ❑ Long Term Care ❑ Closed Door ❑ Compounding

❑ Pharmacy within a hospital, clinic, or medical center ❑ Other:_____

1. How long has your pharmacy been open for business? _____

2. What is the approximate percentage of your prescription drug business?

Walk-in: ____% Fax & Phone: ____% E-Script: ____% Mail Order: ____% Internet: ____%

3. What is the approximate percentage of payment method your pharmacy receives?

Insurance: ____% Medicare/Medicaid: ____% Worker's Compensation: ____% Cash: ____%

4. Which RX suppliers have you used within the last 12 months?

_____ _____ _____

_____ _____ _____

5. Has your pharmacy ever operated under a different name? _____

6. Is your pharmacy affiliated with another pharmacy? If yes, please provide name and address:

_____

7. Has the owner, Pharmacist in Charge, or pharmacy had a license suspended or revoked? This includes from inception to present on the state or DEA license. ❑ Yes ❑ No (Please attach a copy of the disciplinary action and resolution)

8. Has the owner, Pharmacist in Charge, or pharmacy had disciplinary action on a license? This includes from inception to present on the state or DEA license. ❑ Yes ❑ No (Please attach a copy of the disciplinary action and resolution)

9. Is your pharmacy licensed to ship outside the state in which it is located?

❑ Yes ❑ No (If yes, please supply a copy of the license)

10. Does your pharmacy have a website? If yes, please provide web address: _____

11. Do you have a system in place to notify you if one or more prescribing physicians are writing a high percentage of controlled substance prescriptions being filled by your pharmacy? If yes, please describe your procedure:

_____

_____

12. On average how many <u>total</u> (non-controlled and controlled) scripts do you dispense daily? _____

13. On average how many controlled scripts do you dispense daily? _____

14. Approximately what is your monthly dispensing average for the following items:

    A. Monthly Volume of Oxycodone 30mg: _____ Scripts_____ Tabs
    B. Monthly Volume of Oxycodone 10/325mg: _____ Scripts_____ Tabs
    C. Monthly Volume of all **OTHER** strengths of Oxycodone: _____ Scripts_____ Tabs
    D. Monthly Volume of Oxycodone family (all strengths) : _____ Scripts_____ Tabs
    E. Monthly Volume of Hydrocodone 10/325mg: _____ Scripts_____ Tabs
    F. Monthly Volume of all **OTHER** strengths of Hydrocodone: _____ Scripts_____ Tabs
    G. Monthly Volume of Hydrocodone family (all strengths): _____ Scripts_____ Tabs
    H. Monthly Volume of Gabapentin (all strengths): _____ Scripts_____ Tabs

PHARMACY PICTURE REQUIREMENT
Please send the following pictures of your pharmacy: 1- Building with sign, 1- Street view, 1- Posted business hours, 2- Prescription product storage and shelving, 2- Inside of pharmacy retail and waiting area.   **Questionnaires can be submitted via fax, email, or upload portal on the Auburn website. Pictures can be emailed or submitted through the upload portal on the Auburn website. Pictures cannot be faxed. The questionnaire will be pending approval until pictures are received.**

I, _____ as the ❑ owner ❑ representative, have completed this form to the best of my knowledge and ability.

Printed Name: _____ Signature: _____

Title: _____ Date: _____

FOR OFFICE USE ONLY			
State License Verification	**Date: _____**	**Initials: _____**	**City Population: _____**
DEA License Verification	**Date: _____**	**Initials: _____**	**Customer Ratio: _____**
ARCOS Lookup	**Date: _____**	**Initials: _____**	
Notes			
Approved By: _____			**Date: _____**