AstraZeneca Pharmaceuticals, LP
340B Limited Distribution Contract Pharmacy Selection Form

AstraZeneca, at its sole discretion, will allow an eligible 340B covered entity[1] that does not have any in-house pharmacy location set up as a shipping address in the OPA database, to designate one contract pharmacy location that may be used as a "ship to" location for 340B priced product. This election is to be made with respect to the Parent 340B ID and will apply to any child sites. AstraZeneca retains the right to change this discretionary discount practice at any time. The 340B covered entity remains responsible for all aspects of 340B program compliance with respect to product billed to the covered entity, regardless of the shipping location.

Name of 340B Covered Entity ("Institution"): _____

To be valid, form **must** be completed by an individual employed by the Institution . Please submit name and address information in the same format as reflected in the HRSA data base.

Address: _____

City, State, Zip Code: _____

Phone #: _____ 340B ID: _____

Current Authorized Wholesaler: _____ City, State: _____

Secondary Authorized Wholesaler: _____ City, State: _____

Contract Pharmacy:

Contracted pharmacy **must** be listed as a valid contracted Pharmacy on the 340B record listed above (Institution) on HRSA database.

Name of Contract Pharmacy: _____

Address: _____

City, State, Zip Code: _____

HIN (if available): _____ DEA: _____

Contract Pharmacy Selection Declaration:

By signing this document , Institution is acknowledging that this Contract Pharmacy is the only shipping destination for product purchased under this agreement. If Institution requires a change to their Contract Pharmacy Selection, a new 340B Limited Distribution Contract Pharmacy Selection Form must be submitted to AstraZeneca

Contract Pharmacy Selection Updates:

Institution is limited to changing Contract Pharmacy selection once per calendar year unless selected Contract Pharmacy is no longer eligible on the HRSA database.

Effective Date: _____

The Contract Pharmacy Selection Form must be submitted to membership@astrazeneca.com at least ten (10) business days prior to the Effective Date.

Institution acknowledges its obligation to comply with all applicable laws and regulation regarding the purchase of Products under this form, including the requirements of 42 U.S.C. 256b. Institution is hereby informed that there may be an obligation to report discounts to the Department of Health and Human Services or applicable state agency. See 42 C.F.R. 1001.952 (h)(I), (3). Institution agrees to forgo all other discounts for the same products. Institution hereby recognizes that should any discount be provided by AstraZeneca to Institution in error, AstraZeneca is hereby authorized to invoice Institution to collect any discount provided in error to Institution. Institution agrees to pay such invoice within thirty (30) days of receipt of an invoice . Institution reserves the right to review all information used by AstraZeneca in determining the amount of discounts provided in error. Institution agrees to allow AstraZeneca and/or its auditor to have access to any information in Institution's control that relates to AstraZeneca Products necessary to audit 340B purchases.

_____ _____
Authorized Representative of Institution (Signature) **Title**

_____ _____
Authorized Representative of Institution (Printed Name) **Date**

Please send completed form to AstraZeneca at membership@astrazeneca.com

[1] The term 340B Covered Entity is inclusive of the Parent and Child Sites.