



Date: 09/22/2026

[illegible]



# Standard Pharmaceutical Product and Medical Device Information (Rx Product Only)

Version 2021

For Designated Drop Ship Only Products, Please Use Page 3

| MATERIAL HAZARD CLASSIFICATION and TRANSPORTATION                                               |                          |    |                                             |
|-------------------------------------------------------------------------------------------------|--------------------------|----|---------------------------------------------|
| Is this product (check all that apply):                                                         |                          |    |                                             |
| a. Cytotoxic?                                                                                   | <input type="checkbox"/> | No |                                             |
| b. CA Prop. 65 Carcinogen or Reproductive Toxicant?                                             | <input type="checkbox"/> | No |                                             |
| Is the product a CA Prop 65 carcinogen?                                                         | <input type="checkbox"/> | No |                                             |
| Is the product a CA Prop 65 reproductive toxicant?                                              | <input type="checkbox"/> | No |                                             |
| Does the product label bear a CA Prop 65 warning?                                               | <input type="checkbox"/> | No |                                             |
| c. Contact Hazard?                                                                              | <input type="checkbox"/> | No |                                             |
| d. Does this product require special clean-up instructions?                                     | <input type="checkbox"/> | No |                                             |
| (If yes, attach SDS with special instructions.)                                                 |                          |    |                                             |
| e. Does the product contain DEHP?                                                               | <input type="checkbox"/> | No |                                             |
| Is this product regulated for shipment by DOT?                                                  | <input type="checkbox"/> | No |                                             |
| (if yes, answer a-e below and provide SDS)                                                      |                          |    |                                             |
| a. UN/Identification Number                                                                     |                          |    |                                             |
| b. Proper Shipping Name                                                                         |                          |    |                                             |
| c. DOT Hazard Class                                                                             |                          |    |                                             |
| d. Packing Group                                                                                |                          |    |                                             |
| e. Inhalation Hazard?                                                                           | <input type="checkbox"/> | No |                                             |
| Is this product regulated for shipment by IATA?                                                 | <input type="checkbox"/> | No |                                             |
| (if yes, answer a-e below and provide SDS)                                                      |                          |    |                                             |
| a. UN/Identification Number                                                                     |                          |    |                                             |
| b. Proper Shipping Name                                                                         |                          |    |                                             |
| c. DOT Hazard Class                                                                             |                          |    |                                             |
| d. Packing Group                                                                                |                          |    |                                             |
| e. Inhalation Hazard?                                                                           | <input type="checkbox"/> | No |                                             |
| Is the product restricted for air shipment? If so, indicate restriction:                        |                          |    |                                             |
| <input type="checkbox"/> Passenger                                                              |                          |    |                                             |
| <input type="checkbox"/> Cargo                                                                  |                          |    |                                             |
| <input type="checkbox"/> Passenger & Cargo                                                      |                          |    |                                             |
| Is this a reportable quantity?                                                                  | <input type="checkbox"/> | No |                                             |
| RQ Threshold:                                                                                   |                          |    |                                             |
| Is this a marine pollutant?                                                                     | <input type="checkbox"/> | No |                                             |
| Is this product shipped utilizing an authorized DOT exception or Special Permit?                |                          |    |                                             |
| <input type="checkbox"/> No                                                                     |                          |    |                                             |
| (if yes, identify method below)                                                                 |                          |    |                                             |
| <input type="checkbox"/> Limited Quantity                                                       |                          |    |                                             |
| <input type="checkbox"/> Consumer Commodity, ORM-D                                              |                          |    |                                             |
| <input type="checkbox"/> Small Quantity (49 CFR 173.4)                                          |                          |    |                                             |
| <input type="checkbox"/> Special Permit; DOT-SP                                                 |                          |    |                                             |
| <input type="checkbox"/> Special Provision (listed in Column 7 of 49 CFR 172.101);              |                          |    |                                             |
| SP#                                                                                             |                          |    |                                             |
| ADD'L STORAGE INFORMATION                                                                       |                          |    |                                             |
| Is the Product...                                                                               |                          |    |                                             |
| Controlled Substance?                                                                           | <input type="checkbox"/> | No | Controlled Substance Code                   |
| Controlled by State(s)?                                                                         | <input type="checkbox"/> | No | Listed Chemical (List I or II)              |
| ARCOS Reportable?                                                                               | <input type="checkbox"/> | No | If yes, indicate which:                     |
| Schedule No.                                                                                    | <input type="checkbox"/> | 5  | Is it a scheduled listed chemical product?: |
| CLASS OF TRADE RESTRICTION:                                                                     |                          |    |                                             |
| No restriction: Select YES if sold to retail pharmacy, hospitals, clinics and physician offices | <input type="checkbox"/> |    |                                             |
| Restricted to retail pharmacy only:                                                             | <input type="checkbox"/> |    |                                             |
| Restricted to hospital, clinics, and physician offices only:                                    | <input type="checkbox"/> |    |                                             |
| Restricted from US territories? (explain in comments)                                           | <input type="checkbox"/> |    |                                             |
| Comments:                                                                                       |                          |    |                                             |
| MISCELLANEOUS NOTES and/or Image of Product Barcode:                                            |                          |    |                                             |
|                                                                                                 |                          |    |                                             |

| SDS Hazard Classification                                                    |                                         |
|------------------------------------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Organic                                             | <input type="checkbox"/> Corrosive      |
| <input type="checkbox"/> Inorganic                                           | <input type="checkbox"/> Oxidizer       |
| <input type="checkbox"/> Steroid/Androgen                                    | <input type="checkbox"/> Contact Hazard |
| Does the product have an Aerosol class? If yes, identify NFPA Storage Level: | <input type="checkbox"/> No             |
| NFPA Storage Level:                                                          |                                         |
| Is the product a NIOSH hazardous drug?                                       | <input type="checkbox"/> No             |
| If yes, indicate which:                                                      |                                         |

| Hazardous Waste Identification |                       |
|--------------------------------|-----------------------|
| EPA Hazardous Waste Code:      | Waste Characteristics |

| REMS or REGISTRY RESTRICTIONS                       |                             |
|-----------------------------------------------------|-----------------------------|
| Is there a REMS on this product?                    | <input type="checkbox"/> No |
| If Yes, is it managed with a pharmacy registry?     | <input type="checkbox"/>    |
| Website URL:                                        |                             |
| Med Guide Required                                  | <input type="checkbox"/> No |
| Limited Distribution Requirement                    | <input type="checkbox"/> No |
| Comments / Details: (For example, iPledge program?) |                             |
| REMS:                                               | <input type="checkbox"/> No |
| REMS Program Manager Name:                          |                             |
| Supplier Manages REMS registry exclusively:         |                             |
| Wholesale distributor support:                      |                             |
| Provider Name:                                      |                             |
| Site Enrollment Number assigned by Supplier:        |                             |
| DEA #:                                              |                             |
| NCPDP#:                                             |                             |
| NPI #:                                              |                             |
| Comments                                            | IT IS NOT A REMS PRODUCT    |
| Registry:                                           | <input type="checkbox"/> No |
| Registry Program Contact Name:                      |                             |
| Comments                                            | IT IS NOT A REMS PRODUCT    |

| RETURN INSTRUCTIONS                                                             |                                                                                                                                                                             |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Contact tel. # if product received damaged:                                     |                                                                                                                                                                             |
| Is product returnable for credit:                                               |                                                                                                                                                                             |
| URL/Link to returns policy:                                                     | <a href="https://creekwoodpharma.com/wp-content/uploads/2023/07/Return-Goods-Policy.pdf">https://creekwoodpharma.com/wp-content/uploads/2023/07/Return-Goods-Policy.pdf</a> |
| Special regulations or returns requirements for this product in certain states? |                                                                                                                                                                             |
| If so, which states? Other requirements? Comments?                              |                                                                                                                                                                             |



## Standard Pharmaceutical Product and Medical Device Information (Rx Product Only)

Version 2021

FOR DESIGNATED DROP SHIP PRODUCT ONLY - if not a designated drop ship, do not complete.

| Order Method for Designated Drop Ship Product                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Standard Order Receipt and Processing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------|--------------------------|------------|--------------------------|-------------|--------------------------|----------|--------------------------|------------|----------------------|---------------|--------------------------|---------------|----------------------|---------------------------|--------------------------|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Purchase orders may be accepted by:</p> <table border="0"><tr><td>a. EDI</td><td><input type="checkbox"/></td><td>Fax Number:</td><td><input type="text"/></td></tr><tr><td>b. Autofax</td><td><input type="checkbox"/></td><td>Fax Number:</td><td><input type="text"/></td></tr><tr><td>c. Fax</td><td><input type="checkbox"/></td><td>Phone No.:</td><td><input type="text"/></td></tr><tr><td>d. Phone only</td><td><input type="checkbox"/></td><td>Site Address:</td><td><input type="text"/></td></tr><tr><td>e. Supplier Web Site only</td><td><input type="checkbox"/></td><td></td><td></td></tr></table> <p>Minimum Order Quantity: <input type="text"/> Units</p> <p>Supplier's Customer Service Number: <input type="text"/></p> <p>Contracted 3PL company / contact #: <input type="text"/></p> <p>Name: <input type="text"/> Direct customer solutions (R &amp; S)</p> <p>Phone: <input type="text"/> 1-800-655-7556</p> | a. EDI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> | Fax Number:          | <input type="text"/>     | b. Autofax | <input type="checkbox"/> | Fax Number: | <input type="text"/>     | c. Fax   | <input type="checkbox"/> | Phone No.: | <input type="text"/> | d. Phone only | <input type="checkbox"/> | Site Address: | <input type="text"/> | e. Supplier Web Site only | <input type="checkbox"/> |  |  | <p><b>Purchase order daily receipt cut off time by supplier</b></p> <p>Cut off time: <input type="text"/></p> <p>Shipping lead time of PO: <input type="text"/> Hours <input type="text"/> Days</p> <p>Ships same day for next day receipt: <input type="checkbox"/></p> <p>Ships for second day receipt: <input type="checkbox"/></p> <p>Ships regular ground for 3-10 days receipt: <input type="checkbox"/></p> |
| a. EDI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Fax Number:              | <input type="text"/> |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| b. Autofax                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Fax Number:              | <input type="text"/> |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| c. Fax                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Phone No.:               | <input type="text"/> |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| d. Phone only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Site Address:            | <input type="text"/> |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| e. Supplier Web Site only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Expedited Freight Charges or Other Designated Drop Ship Fees:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Overnight and Priority Overnight PO Processing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p>Expedited freight fees billed with each order: <input type="text"/></p> <p>Drop Ship service fee billed with each order: <input type="text"/></p> <p>Drop Ship miscellaneous fees billed: <input type="text"/></p> <p>Comments: <input type="text"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p><b>Overnight receipt available:</b> <input type="checkbox"/></p> <p>PO Receipt cut off time: <input type="text"/></p> <p>Days of week overnight is available:</p> <table border="0"><tr><td><input type="checkbox"/></td><td>Monday</td></tr><tr><td><input type="checkbox"/></td><td>Tuesday</td></tr><tr><td><input type="checkbox"/></td><td>Wednesday</td></tr><tr><td><input type="checkbox"/></td><td>Thursday</td></tr><tr><td><input type="checkbox"/></td><td>Friday</td></tr></table> <p><b>Priority Overnight receipt available:</b> <input type="checkbox"/></p> <p>PO Receipt Cut off time: <input type="text"/></p> <p><b>Saturday Overnight receipt available:</b> <input type="checkbox"/></p> <p>PO Receipt Cut off time: <input type="text"/></p> <p>Order receipt method: <input type="text"/></p> <p>Phone: <input type="text"/> Phone #: <input type="text"/></p> <p>Fax: <input type="text"/> Fax #: <input type="text"/></p> <p>EDI: <input type="text"/></p> <p>Overnight Fees apply: <input type="checkbox"/></p> <p>Other fees apply: <input type="checkbox"/></p> | <input type="checkbox"/> | Monday               | <input type="checkbox"/> | Tuesday    | <input type="checkbox"/> | Wednesday   | <input type="checkbox"/> | Thursday | <input type="checkbox"/> | Friday     |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Monday                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Tuesday                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Wednesday                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Thursday                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Friday                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Class of Trade Restriction:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p>No restriction: Select YES if sold to retail pharmacy, hospitals, clinics and physician offices <input type="checkbox"/></p> <p>Restricted to retail pharmacy only: <input type="checkbox"/></p> <p>Restricted to hospital, clinics, and physician offices only: <input type="checkbox"/></p> <p>Restricted from US territories? (explain in comments) <input type="checkbox"/></p> <p>Comments: <input type="text"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Other Data Information Required to Process PO:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Return Instructions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p>Patient Procedure Date: <input type="text"/></p> <p>Physician Name: <input type="text"/></p> <p>Physician/Clinic Phone #: <input type="text"/></p> <p>Physician State License #: <input type="text"/></p> <p>Physician/Clinic DEA #: <input type="text"/></p> <p>Physician/Clinic Specialty: <input type="text"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <p>Contact # if product is received damaged: <input type="text"/></p> <p>Is product returnable for credit: <input type="checkbox"/></p> <p>URL/Link to returns policy: <input type="text"/></p> <p>Special regulations or returns requirements for this product in certain states? <input type="checkbox"/></p> <p>If so, which states? Other requirements? Comments? <input type="text"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Miscellaneous Notes:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ADDITIONAL INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <p>Is product order for scheduled patient procedure? <input type="checkbox"/></p> <p>Is product order for restocking purposes? <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                      |                          |            |                          |             |                          |          |                          |            |                      |               |                          |               |                      |                           |                          |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                    |