ASTRAZENECA PHARMACEUTICALS LP
FluMist®Quadrivalent (Influenza Vaccine Live, Intranasal)
GROUP PURCHASING ORGANIZATION DECLARATION FORM

To comply with AstraZeneca Pharmaceuticals LP. Single Dedication Policy, please accept this declaration form that:

_____
(Facility Name)

("**Facility**") is confirming **CCPA Purchasing Partners, LLC**
(Group Purchasing Organization & Sub-Group, if applicable)
as the exclusive Group Purchasing Organization ("**GPO**") for contract eligibility with AstraZeneca.

This document will serve as written confirmation of the exclusive GPO of choice by Facility and will remain in effect and on file until further written confirmation of a change has been received and approved by AstraZeneca. AstraZeneca, as referred to herein, shall mean AstraZeneca Pharmaceuticals L.P. ("**AstraZeneca**") for all Products identified by an AstraZeneca product code, labeler code, or National Drug Code (NDC) number. The undersigned agrees to permit AstraZeneca to at least annually audit, on reasonable notice and during normal business hours, the relevant records and books of the undersigned. The undersigned certifies on behalf of Facility that all data submitted by Facility to the exclusive GPO of choice or to AstraZeneca for chargebacks and other reimbursements relating to purchases by Facility under the AstraZeneca contract with the exclusive GPO of choice must be data originating from the purchases of AstraZeneca Product bearing AstraZeneca 11-digit National Drug Code, as assigned by the United States Food and Drug Administration. In addition, all applicable federal and state laws must be adhered to. The undersigned certifies on behalf of Facility that:

i) Facility's pharmacy(ies) that dispense(s) AstraZeneca Products which are the subject of the Agreement between AstraZeneca and the exclusive GPO choice are located, licensed, and registered within the United States of America; and
ii) AstraZeneca Products purchased under the AstraZeneca Agreement with the exclusive GPO of choice are for its "own use," and no Products purchased under the AstraZeneca Agreement with the exclusive GPO of choice may be commercially resold or redistributed to any other entity or person. Sales and/or redistribution of said Products to any other type of entity, account, or third party will be a violation of such contract and, in addition to pursuing any other remedies that AstraZeneca may have available at law or equity, AstraZeneca may terminate your right to receive Products and/or reimbursements under said contract.

Authorized Signature: Date	Facility Name:
Printed Name:	Address:
Job Title:	City, State, ZIP Code:
Phone Number:	HIN (preferred): DEA (optional):
Fax Number:	Email:

Please check √ the box which best describes your facility:

- □ Clinic
- □ HMO Facility
- □ Home Health
- Hospice
- □ Oncology Center
- □ Physician / Practitioner
- □ Rehabilitation Facility
- □ Surgery Center / Freestanding Surgical Facility
- □ Long Term Care (Nursing Home / Nursing Home Provider) (Nursing Home Provider – Sales of products purchased are limited to licensed nursing homes, approved correctional facilities, and other long-term care facilities for their own use.)
- □ Other (if checked, please specify) _____

Please return completed forms to: Membership@astrazeneca.com

AstraZeneca **INTERNAL PURPOSES ONLY**
DEA/HIN #: _____ **CID #:** _____ **Receipt Date:** _____
Current Dedication: _____ **Entered By:** _____

This GPO Declaration Form will be effective 10 days from Receipt Date by AstraZeneca.

This Form contains confidential and sensitive information
PLEASE NOTE: All Facilities are subject to the approval of AstraZeneca