

**From:** CN=Carrie Bennett/OU=Anda/OU=Anda/O=Andrx  
**Sent:** Friday, August 3, 2007 4:03 PM  
**To:** CN=Al Paonessa III/OU=Anda/O=Andrx@Andrx; CN=Tracy Paonessa/OU=VIP/O=Andrx@Andrx; CN=Dominic Floro/OU=VIP/O=Andrx@Andrx; CN=Michael Cochrane/OU=Anda/OU=Anda/O=Andrx@Andrx; CN=Becky Gross/OU=Anda/O=Andrx@Andrx; CN=Patrick Cochrane/OU=Anda/O=Andrx@Andrx; CN=Marc Falkin/OU=Anda/OU=Anda/O=Andrx@Andrx; CN=Kim Bloom/OU=Anda/O=Andrx@Andrx  
**Subject:** Re: Control Limit Letter - Final Final Draft  
**Attach:** Customer Questionnaire.doc; Questionnaire Cover letter.doc

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Here is the updated final draft for Al to sign. The changes that VIP suggested have been made.

Thank you,

Carrie Bennett  
Customer Service Manager  
Anda, Inc.  
Ph. 800-331-2632 x4678  
Fax 866-204-3380  
carrie.bennett@watson.com

-----Carrie Bennett/Anda/Anda/Andrx wrote: -----

To: Al Paonessa III/Anda/Andrx@Andrx, Tracy Paonessa/VIP/Andrx@Andrx, Dominic Floro/VIP/Andrx@Andrx  
From: Carrie Bennett/Anda/Anda/Andrx  
Date: 08/03/2007 11:21AM  
cc: Michael Cochrane/Anda/Anda/Andrx@Andrx, Becky Gross/Anda/Andrx@Andrx, Patrick Cochrane/Anda/Andrx@Andrx  
Subject: Re: Control Limit Letter

Here is the final draft of the cover letter and the questionnaire. If anyone has any questions or changes please let me know otherwise please advise me and Becky of your approval so we can start making up the packets to send out.

Thank you,

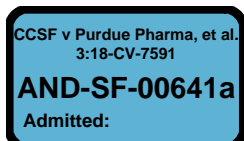
Carrie Bennett  
Customer Service Manager  
Anda, Inc.  
Ph. 800-331-2632 x4678  
Fax 866-204-3380  
carrie.bennett@watson.com

-----Al Paonessa III/Anda/Andrx wrote: -----

Confidential

Anda\_Opioids\_MDL\_0000275572

AND-SF-00641a.00001



To: Michael Cochrane/Anda/Anda/Andrx@Andrx  
From: Al Paonessa III/Anda/Andrx  
Date: 08/03/2007 11:11AM  
cc: Becky Gross/Anda/Andrx@Andrx, Carrie Bennett/Anda/Anda/Andrx@Andrx, Patrick Cochrane/Anda/Andrx@Andrx  
Subject: Re: Control Limit Letter

Mike,

Did Tracey review and approve the letter?

Also, need Executive Vice President/ added to the title.

Albert Paonessa III  
Anda, Inc.  
EVP/COO  
954-217-4500, ext. 4778  
Michael Cochrane/Anda/Anda/Andrx

Michael Cochrane/Anda/Anda/Andrx  
08/03/2007 10:07 AM

To

Becky Gross/Anda/Andrx@Andrx

cc

Al Paonessa III/Anda/Andrx@Andrx, Carrie Bennett/Anda/Anda/Andrx@Andrx, Patrick Cochrane/Anda/Andrx@Andrx

Subject

Re: Control Limit Letter

Looks fine to me as well. Updating the letter is fine since we are using the DHL/Anda envelopes. I can have customer returns route to me through Jay or Miguel.

Thanks  
Mike

Becky Gross/Anda/Andrx

Becky Gross/Anda/Andrx

08/03/2007 10:01 AM

To

Patrick Cochrane/Anda/Andrx@Andrx, Michael Cochrane/Anda/Anda/Andrx@Andrx, Al Paonessa III/Anda/Andrx@Andrx

cc

Carrie Bennett/Anda/Anda/Andrx@Andrx

Subject

Re: Control Limit Letter

The letter looks good to me, please confirm if we are all in agreement to print. Would like to start working on the stuffing of envelopes as soon as possible today.

\*The return envelopes will actually be our Co-Branded DHL/Anda envelopes and will come back attention C2 department. Would like to update that comment on letter.

Thanks!

-----Kim Bloom/Anda/Andrx wrote: -----

To: Patrick Cochrane/Anda/Andrx@Andrx, Michael Cochrane/Anda/Anda/Andrx@Andrx, Al Paonessa III/Anda/Andrx@Andrx  
From: Kim Bloom/Anda/Andrx  
Date: 08/02/2007 05:54PM  
cc: Becky Gross/Anda/Andrx@Andrx  
Subject: Control Limit Letter

Attached is the letter that will be mailed to the 1,200 customers we identified to receive.

Please review and advise if OK to send. Becky will be handling in my absence, so please direct her as needed.

Thanks

Kim Bloom  
Sr. Director, Sales Operations  
Anda, Inc.  
954-217-4754 - Customer Questionnaire.doc - Questionnaire Cover letter.doc

# CUSTOMER QUESTIONNAIRE

1. Pharmacy Name \_\_\_\_\_
  - a. Pharmacy's DBA (doing business as), if any \_\_\_\_\_
  - b. Has the pharmacy ever operated under a different name?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide the Name: \_\_\_\_\_
  
2. If existing ANDA/VIP customer:
  - a. Has been customer of ANDA/VIP: Years \_\_\_\_\_ Months \_\_\_\_\_
  - b. Customer's current ratio of CS to Non-CS Product by % \_\_\_\_\_
  - c. Customer's total monthly dollar purchase volume \_\_\_\_\_
  - d. Is Customer a Primary \_\_\_\_\_ or Secondary Account \_\_\_\_\_ with ANDA/VIP?
  
3. Pharmacy Address: \_\_\_\_\_
  
4. Pharmacy Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_
  
5. Pharmacy Email Address: \_\_\_\_\_
  
6. Name of pharmacist-in-charge \_\_\_\_\_
  
7. Is this pharmacy affiliated with any other pharmacy?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide the following:  
  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_
  

Note: If there are additional affiliates please attach an additional sheet with the information

  
8. Ownership type: Check one
  - a. Sole Proprietor \_\_\_\_\_ Corporation \_\_\_\_\_ Partnership \_\_\_\_\_  
Other \_\_\_\_\_ (describe)
  - b. If Corporation, state of incorporation \_\_\_\_\_
  - c. If Corporation, Chief Executive Officer \_\_\_\_\_
  
9. Owner(s) name: \_\_\_\_\_
  - a. Owner's DBA (doing business as), if any \_\_\_\_\_
  
10. Owner Business Address: \_\_\_\_\_
  
11. Owner Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

12. Owner Email Address: \_\_\_\_\_
13. Number of years owner has operated pharmacy \_\_\_\_\_
14. Is the Owner a licensed pharmacist?  
Yes \_\_\_\_\_ No \_\_\_\_\_
15. Pharmacy DEA registration #: \_\_\_\_\_
16. Has the Pharmacy ever had a DEA registration suspended or revoked?  
Yes \_\_\_\_\_ No \_\_\_\_\_ if so, give details(when ,why, etc.)  
\_\_\_\_\_  
\_\_\_\_\_
17. Has the Owner ever had a DEA registration suspended or revoked?  
Yes \_\_\_\_\_ No \_\_\_\_\_ if so, give details(when, why, etc.)  
\_\_\_\_\_  
\_\_\_\_\_
18. Pharmacy NCPDP # \_\_\_\_\_
19. Is the Pharmacy a member of any professional associations (NABP, NCPA, APHA, etc.)  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide name(s) \_\_\_\_\_
20. Does the pharmacy have any other certifications? (VIPPS –Verified Internet Pharmacy Practice Sites™, etc.)  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, give specifics \_\_\_\_\_
21. Does the pharmacy have any other license/registration (wholesale, repackager, etc...)?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If so, provide copies.
22. Is the pharmacy a specialty pharmacy?  
Yes \_\_\_\_\_ No \_\_\_\_\_
23. Check the following manners of receiving business and provide what percentage of the total business it comprises:
- |            |           |          |         |
|------------|-----------|----------|---------|
| Walk-In    | Yes _____ | No _____ | _____ % |
| Phone      | Yes _____ | No _____ | _____ % |
| Mail Order | Yes _____ | No _____ | _____ % |
| Fax        | Yes _____ | No _____ | _____ % |
| Internet   | Yes _____ | No _____ | _____ % |
24. Which state(s) does the pharmacy ship into (if any)? \_\_\_\_\_  
\_\_\_\_\_
25. Is the pharmacy licensed for sales in all states it distributes to?

Yes \_\_\_\_\_ No \_\_\_\_\_

26. Are prescriptions written by physicians located in the state in which the patient resides?

Yes \_\_\_\_\_ No \_\_\_\_\_

27. How many prescriptions are filled daily \_\_\_\_\_; monthly \_\_\_\_\_

28. Check the following types of products and provide the approximate percentage of products you expect to purchase from Anda/VIP?

OTC	Yes _____	No _____	_____ % of total purchases
Non-Controlled Rx	Yes _____	No _____	_____ % of total purchases
Controlled Substances	Yes _____	No _____	_____ % of total purchases
Listed Chemicals	Yes _____	No _____	_____ % of total purchases

29. Check the following types of products and provide the approximate percentage of products you expect to purchase from other suppliers?

OTC	Yes _____	No _____	_____ % of total purchases
Non-Controlled Rx	Yes _____	No _____	_____ % of total purchases
Controlled Substances	Yes _____	No _____	_____ % of total purchases
Listed Chemicals	Yes _____	No _____	_____ % of total purchases

30. Please provide a list of names of all suppliers you intend to continue to use

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

31. Please provide a list of names of all suppliers you have used within the last 24 months

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

32. Does the pharmacy expect to order more than 3,000 dosage units of Phentermine a month? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, how much and why? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

33. Does the pharmacy expect to order more than 5,000 dosage units of Hydrocodone a month? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, how much and why? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

34. Does the pharmacy expect to order more than 5,000 dosage units of Alprazolam a month? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, how much and why? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

35. If reason for "Yes" answer to questions 33 & 34 is "Pain Management" clinics/physicians, please list each prescriber with their DEA Registration Number

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36. Does the pharmacy have a web site?

a. Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide web address(es):

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Note: If no, you are required to notify us immediately upon establishing a web site.

37. Is the pharmacy affiliated with a web site?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide web address(es):

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Note: If no, you are required to notify us immediately upon establishing a web site.

38. Check the following types of payments the pharmacy receives for products and provide the approximate percentage of total payments:

Insurance	Yes _____	No _____	_____ % of revenue
Medicare/Medicaid	Yes _____	No _____	_____ % of revenue
Cash	Yes _____	No _____	_____ % of revenue
Other	Yes _____	No _____	_____ % of revenue

If other, provide details \_\_\_\_\_

39. Attach and date photographs of pharmacy building (2 of inside, including counter area & 2 of outside-front and back of pharmacy)

I, as the Owner or [authorized representative or officer of the Owner], declare that I have completed this Customer Questionnaire and to the best of my knowledge and belief the information provided is true, correct and complete.

\_\_\_\_\_  
Name of Entity

\_\_\_\_\_  
Name:

\_\_\_\_\_  
Title:

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





August 3, 2007

Attention: Pharmacist

Dear Valued Customer:

Anda and VIP management continue to review our policies on the distribution of controlled substances. After careful analysis of our total product distribution and marketplace guidance, we have determined that a monthly limit is needed, and have selected 5,000 pills in a product family to be appropriate at this time. We apologize for any hardship this causes to our customers and are working diligently to review business practices for proper allocations per customer.

This change in policy is not tied to your store's specific purchases from us or even your specific usage based on your customer prescriptions, but rather our attempt to comfortably operate using marketplace assumptions of general pharmacy usage. We appreciate your purchase history with us and hope you understand.

Enclosed please find our Pharmacy Questionnaire we are sending to our customers. We ask you to please take the time to complete this questionnaire and return as soon as possible in the enclosed self-addressed prepaid DHL envelope, Attention: CII Order Dept. Please call 1-800-CALL DHL (225 - 5345) to have your prepaid envelope picked up and returned to us.

With this information, we will be able to better understand your business needs with regards to the purchase of controlled substances from our company.

As always, we thank you for your continued support.

Al Paonessa, III  
Executive Vice President / Chief Operating Officer  
Anda, Inc. / VIP  
800-331-2632

2915 Weston Road, Weston, FL 33331 • 800-331-2632