DISTRIBUTION INVOICE

[Wholesaler Name]
[Street Address]
[City, State, Zip]
DEA Reg No: [Number] | State License: [Number]

Invoice #: _____
Date: _____
PO #: _____

SHIP TO (Facility)
[Pharmacy/Hospital Name]
[Address Line 1]
[City, State, Zip]
DEA Reg No: [Number]

BILL TO
[Entity Name]
[Address Line 1]
[City, State, Zip]
Attn: Accounts Payable

NDC Number	Description / Strength / Form	Lot Number	Exp. Date	Qty	Unit Price	Total

Subtotal: $0.00
Shipping/Handling: $0.00
Tax: $0.00

Total Amount Due: $0.00

DSCSA Compliance: This document serves as the Transaction Statement (TS) confirming that the products listed were acquired from a legal source and are in compliance with the Drug Supply Chain Security Act. Pedigree information available upon request.

Storage Requirements: Maintain at controlled room temperature 20C to 25C (68F to 77F) unless otherwise specified on product labeling.