

## Completion Procedure for 590-Controlled Substance Questionnaire

Dear Valued Customer:

Please complete the attached 590-Controlled Substance questionnaire in full and return to [Accountsetup@besse.com](mailto:Accountsetup@besse.com). A completed and approved questionnaire is necessary to be able to place controlled substance orders.

Please include a copy of the following documents with your completed questionnaire:

- State Medical License
- State issued controlled substance registration (if applicable)
- DEA license
- Photos (if applicable)

Again, please complete the questionnaire in full and scan/email to [Accountsetup@besse.com](mailto:Accountsetup@besse.com).

Thank you in advance for your cooperation.

Besse Medical

**Form will not be processed unless all questions are completed**

*This questionnaire is to be completed by the distributor owner/authorized representative and Besse associate during an on-site visit.*

### SECTION I – General Information

- Distributor name (as it appears on the DEA registration): \_\_\_\_\_  
DBA: \_\_\_\_\_  
  
Has the distributor ever operated under another name? Yes  or No  If yes, please list: \_\_\_\_\_  
  
Will Besse be this customer's primary wholesaler? Yes  or No  If no, list primary: \_\_\_\_\_  
If no, what percentage of distributor's business will be serviced from Besse? \_\_\_\_\_
- Distributor address (as it appears on the DEA registration):  
  
Street \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Website: \_\_\_\_\_
- Select the following reason for CSRA review:  
  
New customer:  
 Start-up business.  
 Established business **changing** supplier(s) to Besse. List current supplier(s): \_\_\_\_\_  
 Established business **adding** ABDC as supplier(s). List current supplier(s): \_\_\_\_\_  
  
Existing customer:  
 Change in ownership – indicate account # \_\_\_\_\_  
 Updated CSRA 590 form – indicate account #: \_\_\_\_\_
- What is your total monthly dollar volume from all suppliers? (*startup entities provide estimate*) \_\_\_\_\_
- Does this distributor export? Yes  or No  If yes, does the distributor export controlled substances? Yes  or No
- What percentage of the following describes the distributor's customer segments? Selection(s) should add up to 100%.  
  
Retail \_\_\_\_\_%      Long term care \_\_\_\_\_%      Compounding \_\_\_\_\_%      Internet \_\_\_\_\_%  
Mail order \_\_\_\_\_%      Hospice \_\_\_\_\_%      Specialty \_\_\_\_\_%      Gov't/DOD \_\_\_\_\_%
- Select if you have a current account with any other ABC subsidiary and indicate applicable account #.  
 Besse - account # \_\_\_\_\_  Oncology – account # \_\_\_\_\_  
 MWI – account # \_\_\_\_\_  ASD – account # \_\_\_\_\_  
 ABDC – account # \_\_\_\_\_  ICS – account # \_\_\_\_\_

### SECTION II - Licenses

8. Distributor state license #: \_\_\_\_\_ DEA license #: \_\_\_\_\_
9. Controlled substance state license (if applicable): \_\_\_\_\_
10. Other licenses (exporter, re-packager, etc.): \_\_\_\_\_
11. Please list applicable licenses for ALL states you deliver drug products to.  
\_\_\_\_\_

### SECTION III – Distributor Personnel & Ownership

12. Ownership type (*check all that apply*): Proprietor  Corporation  Partnership
13. Are any of the owners a licensed pharmacist or prescribing physician? Yes  or No  If yes, please list license number(s) and state(s): \_\_\_\_\_
14. Are any of the owners associated with or own another distributor? Yes  or No   
If yes, please provide additional details in the comments and observations section.
15. Please provide ownership information below (*if applicable*):

Owner name	State of residence	Number of years owner has operated as a distributor.	% of ownership

16. Name of manager-in-charge \_\_\_\_\_
17. Name/title of person responsible for regulatory compliance \_\_\_\_\_

### SECTION IV – Sanctions/Discipline

18. Has the distributor had a DEA registration or state license/registration (including any state where the distributor does business) suspended, revoked or disciplined within the last 10 years? Yes  or No  If yes, give details (when, why, etc.)  
\_\_\_\_\_  
\_\_\_\_\_
19. Is this distributor currently part of an active investigation at the federal, state or local level? Yes  or No   
If yes, please provide details (when, why, etc.)  
\_\_\_\_\_  
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### SECTION IV – Sanctions/Discipline (cont.)

20. Has a supplier ever suspended or ceased controlled substance sales to the distributor?

Yes  or No  If yes, give details (when, why, etc.)

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21. Has the owner, family member, or any employee of the distributor had a DEA registration or state license/registration suspended, revoked or disciplined within the last 10 years? Yes  or No  If yes, give details (when, why, etc.)

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### SECTION V – Controlled Substance Purchases

22. Are other businesses or business activities located at the same location (*retail pharmacy, etc.*)? Yes  or No

If yes, identify and explain \_\_\_\_\_

23. Does the distributor service pain management clinics/physicians? Yes  or No  If yes, please list.

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24. Check the following types of products (**based on dosage units**) you expect to purchase from Besse. Selection(s) should add up to 100%.

Non-controlled Rx \_\_\_\_\_% of total purchases

Controlled substances \_\_\_\_\_% of total purchases

HBA/OTC \_\_\_\_\_% of total purchases

Listed chemicals \_\_\_\_\_% of total purchases

25. What is your ratio of out-of-state customers vs in-state customers?

Out-of-state customer ratio \_\_\_\_\_%

In-state customer ratio \_\_\_\_\_%

26. Anticipated or actual usage of the following controlled substance products. Start-up entities please provide estimates:

Item	Monthly purchases values in dosage units
Oxycodone products	
Oxycodone 30 mg IR	
Hydrocodone products	
Hydrocodone ER	
Alprazolam	
Carisoprodol	
Promethazine with codeine (ml)	
Buprenorphine (single component)	
Buprenorphine (Naloxone)	
Methadone	
Hydromorphone	
Oxymorphone	
Amphetamine solids	

### SECTION V – Controlled Substance Purchases

27. Please provide the anticipated or actual usage of the top 5 controlled substance or listed chemical product purchases. Start-up entities please provide estimates:

Controlled substance product	Monthly usage values in dosage units

### SECTION VI – Due Diligence

28. Are orders reviewed to determine if the order is suspicious? Yes  or No

29. Does the distributor have a due diligence program to vet prospective customers and customers that purchase significant quantities of controlled substances? Yes  or No

30. Which of the following are included in your due diligence processes? (*Check all that apply*):

- Customer questionnaire  
  On-site visit  
  Review of dispensing/usage Information  
  Public records/internet search  
 Verification of applicable registrations and licenses  
  Other (Please list): \_\_\_\_\_

### SECTION VII – Comments & Photos

31. Attach and date photographs of distributor building (2 of inside, 1 of **entire exterior front** and 1 of the back of the facility).

Other comments/observations:

### SECTION VIII – ACKNOWLEDGMENT

By signing below, distributor acknowledges that:

Besse relies on the information provided on this form to help determine whether it will distribute controlled substances to Distributor. Distributor agrees to inform Besse of any changes to its business that would impact the accuracy or completeness of the information contained herein.

Besse reserves the right, within its sole discretion, to refuse to ship controlled substances to any customer. Any materially incorrect information on the CSRA Form 590 will be grounds for Besse, at its sole discretion, to immediately cease distribution of any or all controlled substances to Distributor and/or to terminate Besse's relationship with Distributor. Distributor has an effective compliance program and adheres to all requirements imposed upon it for the distribution of controlled substances as promulgated in the CFR and by any applicable federal, state or local board of Distributor or other regulatory body.

Distributor will indemnify and hold harmless Besse, its parent companies, affiliates, subsidiaries, shareholders, officers, directors, employees, agents and representatives from any and all economic damage that results from Distributor providing BESSE with materially incorrect information on this form or from failing to have in place an effective compliance program.

DISTRIBUTOR OWNER/AUTHORIZED REPRESENTATIVE:

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

I, as an authorized Besse representative, have discussed with Owner/Distributor BESSE's commitment to preventing the diversion of prescription drugs and the importance of providing complete and accurate responses on this form.

BESSE ASSOCIATE:

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**\*\*\*IMPORTANT NOTE:** Both Besse associate and distributor owner/authorized representative signatures MUST be present to initiate CSRA review.