

# AmerisourceBergen

Besse Medical

## 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
- Completed CSRA Form 27
- SAMHSA certification (if applicable)
- 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 authorized representative.***

## SECTION I – General Information and Ownership

1. Maintenance & Detox facility name (as it appears on the DEA registration): \_\_\_\_\_

DBA: \_\_\_\_\_

Will BESSE be this customer's primary wholesaler? Yes  or No  If no, list primary: \_\_\_\_\_

2. Corporate entity/holding company/owner name: \_\_\_\_\_

3. Maintenance & Detox facility address (as it appears on DEA registration):

Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Website \_\_\_\_\_

4. 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** BESSE as supplier(s). List current supplier(s): \_\_\_\_\_

Existing customer:

Change in ownership – indicate account # \_\_\_\_\_

Additional account – indicate account #: \_\_\_\_\_

Updated CSRA 590 form – indicate account #: \_\_\_\_\_

5. 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 # \_\_\_\_\_

Smartsources (secondary) – account # \_\_\_\_\_

### SECTION II - Licenses

6. DEA registration #: \_\_\_\_\_ DEA business activity: \_\_\_\_\_
7. State BOP # (if applicable): \_\_\_\_\_ Controlled substance state registration (if applicable): \_\_\_\_\_
8. SAMHSA certification #: \_\_\_\_\_
9. Other licenses: \_\_\_\_\_

### SECTION III – Personnel

10. Who is the ultimate person responsible for record keeping, security and ordering controlled substance medication?  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ License # (if applicable) \_\_\_\_\_
11. Provide the name of the licensed responsible practitioner:  
Name \_\_\_\_\_ License # : \_\_\_\_\_

### SECTION IV – Sanctions/Discipline

12. Has a supplier ever suspended, restricted, or ceased controlled substance sales to the Maintenance & Detox facility?  
Yes  or No  If Yes, please provide details (when, why, etc.)  
\_\_\_\_\_  
\_\_\_\_\_
13. Is this Maintenance & Detox facility currently part of an active investigation at the federal, state or local level? Yes  or No   
If Yes, please provide details (when, why, etc.)  
\_\_\_\_\_  
\_\_\_\_\_
14. Has the Maintenance & Detox facility had a DEA registration or state license/registration suspended, revoked or disciplined within the last 10 years? Yes  or No  If Yes, provide details (when, why, etc.)  
\_\_\_\_\_  
\_\_\_\_\_
15. Has any employee of the Maintenance & Detox facility had a state license/registration suspended, revoked or disciplined within the last 10 years? Yes  or No  If Yes, provide details (when, why, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

## SECTION V – Controlled Substance Usage

16. Does the Maintenance & Detox facility utilize the state Rx monitoring program as part of your process (if applicable)?

Yes  or No

17. Does this facility have written policies/procedures for controlled substances? Yes  or No

18. What is the percentage of the following types of drug products (**based on dosage units**) you expect to purchase from BESSE?

Selection(s) should add up to 100%.

Non-Controlled Legend \_\_\_\_\_% of total purchases.

Controlled Substances \_\_\_\_\_% of total purchases.

19. Please provide the anticipated or actual usage of the top 5 purchased controlled substance products. Start-up entities please provide estimates:

Controlled substance product (name, strength, & form)	Monthly usage values in dosage units

20. What is your ratio of out-of-state patients vs in-state patients?

Out-of-state patients \_\_\_\_\_%

In-state patients \_\_\_\_\_%

21. Types of payments the Maintenance & Detox facility receives (selections should add up to 100%).

Private Insurance: \_\_\_\_\_%

Cash/credit card (excluding co-pays) \_\_\_\_\_%

Medicare/Medicaid \_\_\_\_\_%

Other \_\_\_\_\_% Please list \_\_\_\_\_

22. Check all that apply:

Administering medication  Dispensing medication  both administer and dispense medication

## SECTION VI – Prescriber Information

23. List your top 5 prescribing practitioners of controlled substances products (based on dosage units):

Name	Specialty	DEA registration

24. Are you aware of any disciplinary action/sanctions taken within the last 10 years against any of the above practitioners?

Yes  or No  If Yes, please explain (who, when, etc.) If additional room is needed please use the comments/observations section.

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## SECTION VII – Comments/Observations

25. Other comments/observations:

## SECTION VIII – ACKNOWLEDGMENT

By signing below, customer acknowledges that:

BESSE relies on the information provided on this form to help determine whether it will distribute controlled substances to facility. Facility 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 facility and/or to terminate BESSE's relationship with facility. Facility 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 pharmacy or other regulatory body.

Facility 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 Pharmacy providing BESSE with materially incorrect information on this form or from failing to have in place an effective compliance program.

AUTHORIZED REPRESENTATIVE:

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title