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. 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.

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:

   ☐ 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): ____________________

   ☐ Change in practitioner – indicate existing account #: ____________________

   ☐ Change in ownership – indicate existing account # ____________________

   ☐ Updated CSRA 590 form – indicate existing account #: ____________________

   Reason for updated form:

   ____

   ____

   ☐ Change from Secondary to Primary status – indicate existing account #:____________________

   ☐ Change from RX only purchasing to eligible for control purchasing – indicate existing 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 # ____________________

☐ Smartsource (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.)

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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.)

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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.)

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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.)

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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 in-state vs out-of-state patients?
    In-state patients _________% Out-of-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