Besse® Medical
AmerisourceBergen

Practitioner Questionnaire

<u>Form will not be processed unless all questions are completed</u>

This questionnaire is to be completed by the practitioner or authorized representative.

SECTION I – General Information

1. Practitioner name (as it appears on the DEA registration): ____

2. Practice information: a. Name: ____
   b. Street____
   c. City____
   d. State____
   e. Zip____
   f. Phone: ____
   g. Email ____
   h. Website____

3. Individual owner(s)/ partnership/ corporate entity name: ____

   Please provide ownership information below:

Individual owner name	If licensed practitioner, list all federal/state license #'s	State of residence	# of years owner has operated entity	% of ownership

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 practitioner – indicate account #: ____

   ☐ Change in ownership – indicate account # ____

   ☐ Updated CSRA 590 form – indicate account #: ____

5. What is your total monthly dollar volume from all suppliers? (*start-up entities provide estimate*) ______________________________

6. Has a supplier ever suspended or ceased controlled substance sales to the entity? Yes ☐ or No ☐

7. Is Besse this customer's primary wholesaler? Yes ☐ or No ☐. If no, list primary: ____

   If no, what percentage of practitioner's business will be serviced from ABDC?____

SECTION II - Licenses

8. Practitioner state medical license #: ________________________ Practitioner DEA registration #: __________________________

9. For mid-level practitioners, do you have a supervising physician? Yes ☐ or No ☐ If yes, provide name and license number.
   ____

10. Facility controlled substance state license (*if applicable*): ____________________________

11. List specialty and certifications: ____

12. Does the practitioner have any other licensure/registration, e.g. Data Waived, etc.____?

13. Name/Title of individual responsible for preventing the theft and diversion of controlled substances (*if different than practitioner*).

    Name_____________________________

    Title______________________________ License # (if applicable): ______________________________

SECTION III – Sanctions/Discipline

14. Has the practitioner been sanctioned/ disciplined within the last 10 years in any state(s) where they are or have been licensed?
    Yes ☐ or No ☐. If yes, give details (when, why, etc.)
    ____
    ____

15. Has the practitioner 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.)
    ____
    ____

16. Has the owner or any employee of the practice 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.)
    ____
    ____

SECTION IV – Controlled Substance Purchases

17. Check the following types of products 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.

Does the practitioner **dispense** any medications to patients from the office supply? Yes ☐ or No ☐

18. List top 5 highest volume controlled substances of anticipated purchases or actual usage if that data is available.
Start-up entities please provide estimates:

Item	Monthly usage

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

Out-of-state patients __________% In-state patients _________%

20. Types of payments the practice receives. Selection(s) should add up to 100%:

Private Insurance ____________% of revenue. Cash____________% of revenue.

Medicare/Medicaid____________% of revenue. Other____________% of revenue.

Please list other ____

21. If applicable, at time of onboarding and annually thereafter, practitioner customers located in the following states will be required to provide a 12-month utilization report (DUR) summary of all controlled substances and/or Gabapentin dispensed or otherwise furnished to any patient.

- **OH**

The 12-month DUR must be in electronic format (Excel or CSV) and cannot include any protected health information (PHI). The report should include the following data elements:

1) NDC Number

2) Drug Description (Name, Strength, Dosage form)

3) Quantity dispensed over the past 12-month period (total number of tabs/caps, milliliters (injectable, oral solution / syrup), Grams (topical), Patches.

22. Other comments/observations:

SECTION V – ACKNOWLEDGMENT

By signing below, Practitioner acknowledges that:

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

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

PRACTITIONER/OWNER/AUTHORIZED REPRESENTATIVE:

______________________________	______________________________
Name (Print)	Signature
______________________________	______________________________
Title	Date