

## 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

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

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

## 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:

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 #: \_\_\_\_\_

## SECTION I – General Information (continued)

5. Select if you have an established account with any other AB subsidiary. Please indicate applicable account #.

Oncology Supply – account # \_\_\_\_\_ MWI – account # \_\_\_\_\_

ASD – account # \_\_\_\_\_ ABDC – account # \_\_\_\_\_

ICS – account # \_\_\_\_\_ Smartsources – account # \_\_\_\_\_

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 Besse? \_\_\_\_\_

## 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, license number and a copy of the collaborative agreement -if applicable). \_\_\_\_\_

10. 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.)

\_\_\_\_\_  
\_\_\_\_\_

### SECTION III – Sanctions/Discipline (continued)

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.)-

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17. Has the practitioner, owner, family member or employee of the practice had any administrative, civil, and/or criminal action imposed by any regulatory/law enforcement entity (state, local, federal) within the last 10 years? Yes  or No . If yes, give details (when, why, etc.)

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### SECTION IV – Controlled Substance Purchases

18. 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   
 If yes & located in Ohio, please refer to question 22.

19. List top 5 highest volume controlled substances of anticipated purchases or actual usage if that data is available.

Start-up entities please provide estimates:

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

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

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

21. 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 \_\_\_\_\_

22. 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.

23. 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