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
- 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

Name of Besse associate: _____

Phone of Besse associate: _____

Servicing distribution center(s) _____

This questionnaire is to be completed by the owner or authorized representative and Besse associate.

SECTION I – General Information

1. Pharmacy name (as it appears on the DEA registration): _____

   DBA: _____

   Will Besse be this customer's primary wholesaler? Yes ☐ or No ☐ If no, list primary: _____

   If no, what percentage of pharmacy's business will be serviced from Besse?_____

2. Pharmacy address (as it appears on the DEA registration):

   Street_____ City_____

   State_____ Zip_____ Phone _____

   Email_____ Website _____

3. 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 #: _____

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

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 # _____

6. What percentage of the following describes the pharmacy's business activity? Selection(s) should add up to 100%.

   Retail _____% Long Term Care _____% Compounding _____% Internet _____%

   Mail Order _____% Hospice _____% Specialty_____%

SECTION II - Licenses

7. Pharmacy DEA registration #: _____ DEA business activity: _____

8. State BOP #: _____ Controlled substance state license *(if applicable)*: _____

9. What is the pharmacy's CMEA self-certification number which is required to sell pseudoephedrine products? _____ (refer to: http://www.deadiversion.usdoj.gov/meth/index.html#sales)

10. Other licenses: _____

SECTION III – Pharmacy Personnel & Ownership

11. Pharmacist –In –Charge name: _____License #: _____

12. Pharmacy Manager name (*if different than PIC*): _____ License # (*if applicable*): _____

13. Corporate entity (*if applicable*): _____

14. Please provide ownership information below:

Owner name	State of residence	Number of years owner has operated pharmacy	% of ownership

15. Are any of the owners associated with or own other pharmacies? Yes ☐ or No ☐ If yes, please list.

_____

16. Are any of the owners a licensed pharmacist? Yes ☐ or No ☐ If yes, please list license number(s) and state(s):

_____

17. Are any of the owners a prescribing practitioner at this pharmacy? Yes ☐ or No ☐ If yes, please list license number(s) and state(s):

_____

SECTION IV – Sanctions/Discipline

18. Has a supplier ever suspended, reduced, or ceased controlled substance sales to the pharmacy? Yes ☐ or No ☐
If yes, please provide details (when, why, etc.)

_____

_____

SECTION IV – Sanctions/Discipline (Cont.)

19. Is this pharmacy currently part of an active investigation at the federal, state or local level? Yes ☐ or No ☐ If yes, please provide details (when, why, etc.)

_____

_____

20. Has the Pharmacy 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.)

_____

_____

21. Has the PIC been sanctioned and/or disciplined within the last 10 years in any state(s) where they were licensed as a pharmacist? Yes ☐ or No ☐ If yes, provide details (when, why, etc.)

_____

_____

22. Has the owner, family member, or any employee of the pharmacy 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.)

_____

_____

SECTION V – Prescriptions/Controlled Substance Usage

23. How many prescriptions are filled daily_____; monthly_____? Start-up entities please provide estimates.

24. What is the percentage of prescriptions that are controlled substances_____%.

25. Does the pharmacy utilize the state Rx monitoring program as part of dispensing process? Yes ☐ or No ☐

26. Does this pharmacy have written policies/procedures for dispensing controlled substances? Yes ☐ or No ☐

27. Does the pharmacy fill controlled substance and/or Gabapentin prescriptions for out-of-state patients? Yes ☐ or No ☐
If yes, please indicate which states:

_____

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

Out-of-state patient ratio _____%. In-state patient ratio_____%.

29. What is the percentage of 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.\

SECTION V – Prescriptions/Controlled Substance Usage (cont.)

30. Anticipated or actual usage of the following controlled substances. Start-up entities please provide estimates:

Item	Monthly usage values in dosage units
Oxycodone products	
Oxycodone 30 mg IR	
Hydrocodone products	
Amphetamine Solids	
Alprazolam	
Carisoprodol	
Promethazine w/ codeine (ml)	
Buprenorphine (single component)	
Buprenorphine (Naloxone)	
Hydromorphone	
Oxymorphone	
Methadone	

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

Controlled substance product	Monthly usage values in dosage units	Average dosage units per prescription

SECTION VI – Prescriber Information

32. List your top 5 prescribing practitioners of controlled substances based on dosage units (*not applicable to start-up entities*):

Name	Specialty	DEA registration	# CS prescriptions monthly

33. Are you aware of any disciplinary action/sanctions taken within the past 10 years against any of the above practitioners?
Yes ☐ or No ☐ If Yes, please explain (*who, when, etc*.)

_____

_____

SECTION VII – Payments & Photos

34.Types of payments the pharmacy receives for prescriptions. Selection(s) should add up to 100%:

Private Insurance _____%. Cash/credit card (*excluding co-pays*) _____%.

Medicare/Medicaid_____%. Other_____% Please list: _____

35. What percentage of controlled substance prescriptions are paid in cash/credit cards? _____%

36. Attach and date photos of pharmacy. At least two (2) photos of pharmacy interior, including counter area and front end, and one (1) photo of ***entire exterior front of pharmacy***. Include additional photos that would demonstrate special services provided by the pharmacy (i.e. sterile compounding area). ***(Not applicable for change of ownership not resulting in location change).***

37. Customers located in the following states will be required to provide a 90 Day Drug Utilization Report (DUR) at time of onboarding, as well as on an annual recurring basis:

- **OH**

The 90 day 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 most recent 90-day period (total number of tabs/caps, milliliters (injectable, oral solution / syrup), Grams (topical), Patches.

Time period covered by the report is reflective of all legend drugs (non-control and controlled substances) that were dispensed by the pharmacy.

38. Other comments/observations:

SECTION VIII – ACKNOWLEDGMENT

By signing below, Pharmacy acknowledges that:

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

Pharmacy 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.

PHARMACY AUTHORIZED REPRESENTATIVE:

_____ _____
Name (Print) Signature

_____ _____
Title Date

I, as an authorized AmerisourceBergen Drug Corporation representative, have discussed with Owner/Pharmacy 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 pharmacy authorized representative signatures MUST be present to initiate CSRA review.