

## 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 owner or authorized representative and Besse associate.  
Form will not be processed until ALL questions are answered in full.***

Name of Besse associate: \_\_\_\_\_

Phone of Besse associate: \_\_\_\_\_

Servicing distribution center(s) \_\_\_\_\_

### 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:

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

4. Select if you have a current account with any other ABC subsidiary and indicate applicable account #.

Oncology - account # \_\_\_\_\_  MWI – account # \_\_\_\_\_

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

ICS – account # \_\_\_\_\_  SmartSource – account # \_\_\_\_\_

5. 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

6. Pharmacy DEA registration #: \_\_\_\_\_ DEA business activity: \_\_\_\_\_
7. State BOP #: \_\_\_\_\_ Controlled substance state license (if applicable): \_\_\_\_\_
8. Does the pharmacy have a CMEA self-certification number - required to sell pseudoephedrine products? Yes No  
 If yes, list license # \_\_\_\_\_ (refer to: <http://www.deadiversion.usdoj.gov/meth/index.html#sales>)  
 If no, check one of the following: sell via prescription only/OTC Closed door facility N/A – do not sell.
9. Other licenses: \_\_\_\_\_

### SECTION III – Pharmacy Personnel & Ownership

10. Pharmacist –In –Charge name: \_\_\_\_\_ License #: \_\_\_\_\_
11. Pharmacy Manager name (if different than PIC): \_\_\_\_\_ License # (if applicable): \_\_\_\_\_
12. Corporate entity (if applicable): \_\_\_\_\_
13. Please provide ownership information below:

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

14. Are any of the owners associated with or own other pharmacies? Yes  or No  If yes, please list pharmacy name & DEA registration number.  
 \_\_\_\_\_
15. Are any of the owners a licensed pharmacist? Yes  or No  If yes, please list license number(s) and state(s):  
 \_\_\_\_\_
16. 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

17. Has a supplier ever suspended, reduced, or ceased controlled substance sales to the pharmacy within the last 10 years? Yes  or No  If yes, please provide details (when, why, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_
18. 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.)  
 \_\_\_\_\_  
 \_\_\_\_\_

### SECTION IV – Sanctions/Discipline con't

19. 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.)

---

---

20. Has the PIC, owner, family member or employee of the pharmacy 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, provide details (when, why, etc.)

---

---

21. 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

22. How many prescriptions are filled monthly \_\_\_\_\_? Start-up entities please provide estimates.

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

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

25. Does the pharmacy fill controlled substance and/or Gabapentin prescriptions for out-of-state patients? Yes  or No

If yes, explain the circumstances for filling out of state controlled substance/Gabapentin prescriptions and list applicable states:

---

---

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

In-state patient ratio \_\_\_\_\_%.

Out-of-state patient ratio \_\_\_\_\_%.

27. 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.

28. 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	
Methodone	

29. Provide the anticipated or actual usage of the top 5 controlled substances/listed chemical products to be purchased from Besse if not listed above. Start-up entities please provide estimates.

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

## SECTION VI – Prescriber Information

30. 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

31. 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

32. 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: \_\_\_\_\_

33. What percentage of controlled substance prescriptions are paid in cash/credit cards? \_\_\_\_\_%

34. 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).

**35. 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.

36. 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.