Besse Medical
AmerisourceBergen

Maintenance/Detox Questionnaire

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:

   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 #: _____

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.)

_____

_____

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.)

_____

_____

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.)

_____

_____

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.)

_____

_____

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 out-of-state patients vs in-state patients?

Out-of-state patients _____% In-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.*

_____

_____

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