AmerisourceBergen
MWI Animal Health®

Retail pharmacy questionnaire

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Form will not be processed unless all questions are completed

MWI associate details:

Name: _____ Phone number: _____

Servicing distribution center(s) (DCs): _____

This questionnaire is to be completed by the owner or Pharmacist in charge (PIC) of the retail pharmacy and MWI associate. If you require additional space, please utilize the comments / observations section.

Section I – General information

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

   DBA: _____

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

   Street: _____ City: _____

   State: _____ Zip: _____ Phone: _____

   Email: _____ Website: _____

3. Select the following reason for controlled substancemonitoring program (CSMP) review:

   ☐ Start-up business

   ☐ Established business **changing** supplier(s) to MWI or **adding** MWI as supplier(s)

   ☐ Change in ownership – indicate existing account number: _____

   ☐ Is a Power of Attorney from the prior owner being utilized? Yes ☐ No ☐ If yes, provide a copy

   ☐ Updated CSMP 590 form – indicate account number: _____

   Reason for updated form: _____

   _____

   ☐ Reinstatement to purchase controlled substance and/or listed chemical products: _____

4. Select if you have a current account with AB or any other subsidiary subsidiary and indicate applicable account number: _____

   ☐ Besse Medical: _____ ☐ Oncology Supply: _____

   ☐ AmerisourceBergen: _____ ☐ ASD: _____

   ☐ ICS: _____ ☐ Smartsource: _____

Section II – Pharmacy business model

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

   Retail _____ % Compounding _____ % Closed door _____ % Digital/Internet _____ %

   Mail order _____ % Specialty _____ % Central fill _____ %

6. Is the pharmacy located within a clinic? Yes ☐ No ☐

   If yes, what type of clinic? _____

   Provide name of clinic: _____

7. Does the pharmacy fill controlled substance prescriptions coming from this facility / clinic? Yes ☐ No ☐

   If yes, are there any financial interests with the clinic(s)? Yes ☐ No ☐

8. Does the pharmacy provide controlled substances to other pharmacies, practitioners, or other DEA registrants? Yes ☐ No ☐

9. Does the pharmacy accept walk-in patients? Yes ☐ No ☐

Section III – Licenses

10. Pharmacy DEA registration number: _____ DEA business activity: _____

11. State board of pharmacy number: _____ Controlled substance state license (if applicable): _____

12. Other licenses: _____

13. Is the pharmacy licensed in any other state(s)? Yes ☐ No ☐ If yes, provide state and license number below.

State	State license number

Sectio IV – Pharmacy personnel and ownership

14. Pharmacist-in-charge (PIC) name: _____ License number: _____

15. Has the PIC been licensed in any other state in the past five (5) years? Yes ☐ No ☐

    If yes, please provide state and license number: _____

16. Pharmacy manager name (if different than PIC): _____ License number (if applicable): _____

17. Corporate entity (if applicable): _____

Section IV – Pharmacy personnel and ownership (cont.)

18. Please provide ownership information below:

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

19. Are any of the owners a licensed pharmacist? Yes ☐ No ☐

If yes, please list license number(s) and state(s): _____

20. Are any of the owners a prescribing practitioner at this pharmacy? Yes ☐ No ☐

If yes, please list license number(s) and state(s): _____

21. Are any of the owners associated with or own other pharmacies? Yes ☐ No ☐

If yes, please list pharmacy name and DEA registration number: _____

22. Is the owner a licensed practitioner? Yes ☐ No ☐

If yes, list federal /state license numbers: _____

Pharmacy name	DEA registration number

Section V – Sanctions / discipline

23. Has a supplier suspended, reduced, or ceased controlled substance sales to the pharmacy or other owned pharmacies within the last five (5) years? Yes ☐ No ☐ If yes, please provide details (when, why, etc.)

24. Is this pharmacy or other owned pharmacies currently part of an active investigation at the federal, state or local level? Yes ☐ No ☐

If yes, please provide details (when, why, etc.)

25. Has the pharmacy or other owned pharmacies had a DEA registration or state license / registration suspended, revoked or disciplined within the last five (5) years? Yes ☐ No ☐ If yes, please provide details (when, why, etc.)

Section V – Sanctions / discipline (cont.)

26. Has the PIC, owner or any employee of the pharmacy or other owned pharmacies had any administrative, civil, and/or criminal action (misdemeanor or felony offense) imposed by any regulatory / law enforcement entity (state, local, federal) within the last five (5) years?
Yes ☐ No ☐ If yes, please provide details (when, why, etc.)

27. Has the PIC, owner or any employee of the pharmacy or other owned pharmacies had a DEA registration or state license / registration suspended, revoked or disciplined within the last five (5) years? Yes ☐ No ☐ If yes, please provide details (when, why, etc.)

Section VI – Supplier information

28. Will MWI be this customer's primary wholesaler? Yes ☐ No ☐ If no, list primary: _____
If no, what percentage of pharmacy's business will be serviced from MWI? _____

29. List your **controlled substance (CS) and listed chemical (LC) product** suppliers in the table below.

Current supplier	Supplier type (primary / secondary)	Will you continue to purchase from this supplier? (Yes / No)	What percentage of pharmacy business will be serviced from this supplier?

30. List your **non-controlled legend drug product** suppliers in the table below.

Current supplier	Supplier type (primary / secondary)	Will you continue to purchase from this supplier? (Yes / No)	What percentage of pharmacy business will be serviced from this supplier?

31. **For start-ups only:**
Do you intend to purchase controlled substance and/or listed chemical products from any other supplier? Yes ☐ No ☐
If yes, list other anticipated suppliers:

Do you intend to purchase non-controlled legend drug products from any other supplier? Yes ☐ No ☐
If yes, list other anticipated suppliers:

Section VII – Prescriptions / controlled substance usage

32. How many prescriptions are filled monthly? _____ Start-up entities please provide estimates.

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

    If no, explain in comments/observations section

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

    if no, explain in comments/observations section

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

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

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

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

37. What is the percentage of the following types of products **(based on dosage units)** you expect to purchase from AB?

    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

38. Anticipated or actual usage of the following controlled substances from all suppliers. Start-up entities please provide estimates:

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

39. Provide the anticipated or actual usage of the top five (5) purchased controlled substance or listed chemical products **not listed above**.

    Start-up entities please provide estimates:

Rank	Controlled substance product (name / strength / dosage form)	Monthly usage values in dosage units	Average dosage units per prescription
1			
2			
3			
4			
5			

Section VIII – Controlled substance dispensing / procedure

40. For controlled substance prescriptions, does the pharmacy:

Validate the practitioner's DEA registration via the DEA website? Yes ☐ No ☐

Validate the practitioner's state license(s) via the State board of medicine or other authority website? Yes ☐ No ☐

Contact the practitioner to validate a controlled substance prescription when there are questions or concerns? Yes ☐ No ☐

Check the patient / customer photo ID? Yes ☐ No ☐

Query the state prescription drug monitoring program (PDMP) before dispensing? Yes ☐ No ☐

Have written policies and procedures for identifying and handling questionable or suspicious prescriptions? Yes ☐ No ☐

Provide training and/or copies of policies and procedure to pharmacy personnel? Yes ☐ No ☐

If no to any above questions, provide explanation in comments/observations section

Section IX – Controlled substance security

41. Does the pharmacy conduct criminal background checks on employees with access to controlled substances? [21CFR1301.76(a)]

Yes ☐ No ☐ If no, explain in the comments/observations section

Has any employee with access to controlled substances had a felony conviction related to controlled substances? Yes ☐ No ☐

If yes, has the pharmacy obtained the necessary waiver from the DEA? Yes ☐ No ☐

Has any employee with access to controlled substances had a DEA registration revoked, denied, of surrendered? Yes ☐ No ☐

If yes, has the pharmacy obtained the necessary waiver from the DEA? Yes ☐ No ☐

42. How often are background checks conducted? (e.g. prior to hiring, annually) _____

43. Does the pharmacy have any of the following security measures? Check all that apply.

☐ Alarm system ☐ Security camera(s) ☐ Dedicated CII storage ☐ Security guards ☐ Panic button

44. Has the pharmacy experienced any theft or loss during the past twelve (12) months? Yes ☐ No ☐ If yes, how many? _____

If yes, were they reported to the: DEA? Yes ☐ No ☐ Local law enforcement? Yes ☐ No ☐

If yes, were any employees involved in thefts? Yes ☐ No ☐

Section X – Prescriber information

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

Name	Specialty	DEA registration	Number of controlled substances prescriptions (per month)

Section X – Prescriber information (cont.)

46. Are you aware of any disciplinary and/or law enforcement action taken within the past five (5) years against any of the above practitioners, or any prescriber you fill constrolled substance prescriptions for?

Yes ☐ No ☐ If yes, please explain (who, when, etc.)

47. Are any of the above prescribers located more than 50 miles from the pharmacy? Yes ☐ No ☐

If yes, please explain the reason for the distance

Section XI – Payments and photos

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

Private insurance _____ % Cash / credit card (excluding copays) _____ %

Other _____ % Please list: _____

49. What percentage of controlled substance prescriptions are paid in cash / credit cards? (excluding copays) _____ %

50. 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).

Section XII – Additional comments and observations

51. Please share details below:

Section XIII – Acknowledgment

By signing below, pharmacy acknowledges that:

MWI relies on the information provided on this form to help determine whether it will distribute controlled substances to pharmacy. Pharmacy agrees to inform MWI of any changes to its business that would impact the accuracy or completeness of the information contained herein.

MWI reserves the right, within its sole discretion, to refuse to ship controlled substances to any customer. Any materially incorrect information on the CSMP Form 590 will be grounds for MWI, at its sole discretion, to immediately cease distribution of any or all controlled substances to pharmacy and/or to terminate MWI'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 acknowledges that MWI may need to review Pharmacy's dispensing data as part of MWI's controlled substance monitoring responsibilities, including new customer onboarding, due diligence reviews, and consumption reviews. Pharmacy acknowledges that failure to provide requested dispensing data within a reasonable amount of time of the data being requested by MWI may result in Pharmacy being unable to order controlled substances from MWI. Collection and utilization of dispensing data will be compliant with applicable federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). MWI utilizes a third-party contractor to collect this data. Pharmacy acknowledges that it will need to sign a business associate agreement with MWI's third-party contractor to facilitate the data transfer.

Pharmacy will indemnify and hold harmless MWI, its parent companies, affiliates, subsidiaries, shareholders, officers, directors, employees, agents and representatives from any and all economic damage that results from pharmacy providing MWI with materially incorrect information on this form or from failing to have in place an effective compliance program.

Pharmacy owner of Pharmacist in charge (PIC):

Name	Signature
Title	Date

I, as an authorized MWI representative, have discussed with owner / pharmacy MWI's commitment to preventing the diversion of prescription drugs and the importance of providing complete and accurate responses on this form.

MWI associate:

Name	Signature
Title	Date

Important note: Both MWI representative and pharmacy owner or Pharmacist in Charge (PIC) signatures **must** be present to initiate CSMP review.