AmerisourceBergen
Oncology Supply

Practitioner Questionnaire

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 CSMP review:

☐ Start-up business.

☐ Established business **changing** supplier(s) to Oncology. List current supplier(s):_____

☐ Established business **adding** Oncology as supplier(s). List current supplier(s):_____

☐ Change in practitioner – indicate existing account #: _____

☐ Change in ownership – indicate existing account # _____

☐ Updated CSMP 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 #.

   Besse – account #_____ MWI – account #_____

   ASD – account #_____ AB – account # _____

   ICS – account #_____ Smartsource – account #_____

6. Has a supplier ever suspended or ceased controlled substance sales to the entity? Yes ☐ or No ☐

7. Is Oncology this customer's primary wholesaler? Yes ☐ or No ☐. If no, list primary: _____
   If no, what percentage of practitioner's business will be serviced from Oncology?_____

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 5 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 5 years?
    Yes ☐ or No ☐If yes, give details (when, why, etc.)

    _____

    _____

    _____

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 5 years? Yes ☐ or No ☐. If yes, give details (when, why, etc.)

    _____

    _____

SECTION III – Sanctions/Discipline (continued)

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 5 years? Yes☐ or No☐. If yes, give details (when, why, etc.)

_____

_____

_____

SECTION IV – Controlled Substance Purchases

18. Check the following types of products you expect to purchase from Oncology. 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:

Item (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:

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

Oncology 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 Oncology, at its sole discretion, to immediately cease distribution of any or all controlled substances to Practitioner and/or to terminate Oncology'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 Oncology, its parent companies, affiliates, subsidiaries, shareholders, officers, directors, employees, agents and representatives from any and all economic damage that results from Practitioner providing Oncology 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

***IMPORTANT NOTE:** Practitioner authorized representative signature MUST be present to initiate CSMP review.