This questionnaire is to be completed by the owner or authorized representative and Oncology associate. Form will not be processed until ALL questions are answered in full.

Name of Oncology associate: ______________________________________

Phone of Oncology associate: ______________________________________

Servicing distribution center(s) __________________________________

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 CSMP review:

   ☐ Start-up business.

   ☐ Established business **changing** supplier(s) to Oncology Supply.

   ☐ Established business **adding** Oncology Supply as supplier(s).

   ☐ Change in ownership – indicate existing account # ____

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

   ☐ Additional account – 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 to eligible for control purchasing – indicate existing account #__________________________

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

☐ Besse - account #______________________________ ☐ Oncology – account # _________________________________

☐ MWI – account #_______________________________ ☐ ASD – account # ____________________________________

☐ AB – account # _____________________________ ☐ ICS – account # _____________________________________

☐ Smartsource – account # _____________________________________

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 ______% Long Term Care _______% Compounding _______% Closed Door ______% Internet _______%

Digital Pharmacy _______% Mail Order _______% Hospice _______% Specialty_______% Central Fill _____%

340B account ______% Pain management practitioners/clinics ________% Weight loss clinics _______%

6. Is the pharmacy located within a healthcare facility/clinic? ☐ Yes ☐ No
   If yes, what type of healthcare facility/clinic? ____________________________________
   Provide name of facility/clinic: ____
7. Does the pharmacy fill controlled substance prescriptions coming from this facility/clinic? ☐ 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 #: __________________________ DEA business activity: _______________________________

    NPI #_________________________________
11. State BOP #: ___________________________ Controlled substance state license *(if applicable)*: __________________________
12. 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 ☐ Closed door facility ☐ N/A – do not sell.
13. Other licenses: ____
14. Is the pharmacy licensed in any other state(s)? ☐ Yes ☐ No If yes, provide state and license # below.

State	State License #

SECTION IV – Pharmacy Personnel & Ownership

15. Pharmacist –In –Charge name: ____License #: __________________________
16. Is the PIC licensed in any other state in the past 5 years? ☐ Yes ☐ No
    If yes, provide state and license #____
17. Pharmacy Manager name *(if different than PIC)*: ___________________________ License # *(if applicable)*: _________________
18. Corporate entity *(if applicable)*: ____

SECTION IV – Pharmacy Personnel & Ownership (cont.)

19. Please provide ownership information below:

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

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

____

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

____

22. Are any of the owners associated with or own other pharmacies? Yes ☐ or No ☐ If yes, please list pharmacy name & DEA registration number.

Pharmacy Name	DEA registration

SECTION V – Sanctions/Discipline

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

____

____

SECTION VI – Supplier Information

28. Will Oncology be this customer's primary wholesaler ☐ Yes ☐ No If no, list primary:__________________

If no, what percentage of pharmacy's business will be serviced from Oncology? _______________

Signed Prime Vendor Agreement (PVA)? Yes ☐ or No ☐

PVA or equivalent with any other wholesaler? Yes ☐ or No ☐ If yes, who? _____________________________

29. List your controlled substance & listed chemical product suppliers in the table below.

Current supplier	Supplier Type (primary/secondary)	Will you continue to purchase CS/LC from this supplier? (Yes/No)	What % 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 CS/LC from this supplier? (Yes/No)	What % 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 ☐ or No ☐

If yes, list other anticipated suppliers: ____

Do you intend to purchase non-controlled legend drug products from any other supplier? Yes ☐ or 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 ☐ or No ☐

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

35. 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:
____
____

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 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.

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

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

39. Provide the anticipated or actual usage of the top 5 purchased controlled substance or listed chemical products 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 VIII - Controlled Substance Dispensing/Procedure

40. For controlled substance prescriptions, does the pharmacy:

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

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

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

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

Query the state PDMP before dispensing? Yes ☐ or No ☐

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

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

SECTION IX - Controlled Substance Security

41. Does the pharmacy conduct criminal background checks on employees involved in the handling of controlled substances?

Yes ☐ or 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 12 months? Yes ☐ or No ☐ If yes, how many? ____________

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

Were any employees involved in thefts? Yes ☐ or No ☐

SECTION X– Prescriber Information

45. 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

SECTION X – Prescriber Information (cont.)

Additional Prescriber Information

Only to be completed if requested by CSMP Diversion Control Team

Name	Specialty	DEA registration	# CS Prescriptions monthly

46. Are you aware of any disciplinary action/sanctions taken within the past 5 years against any of the above practitioners?
    Yes ☐ or No ☐ If Yes, please explain (*who, when, etc*.)

____

____

47. Are any of the above prescribers located more than 50 miles from the pharmacy? Yes ☐ or No ☐ If yes, please explain the reason for the distance.

____

____

SECTION XI – Payments & Photos

48. 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: ____________________________________

49. What percentage of controlled substance prescriptions are paid in cash/credit cards? (*excluding co-pays*) __________%

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).

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.

Additional Comments & Observations:

ACKNOWLEDGMENT

By signing below, Pharmacy acknowledges that:

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

Oncology Supply 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 Supply, at its sole discretion, to immediately cease distribution of any or all controlled substances to Pharmacy and/or to terminate AB'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 Oncology Supply, its parent companies, affiliates, subsidiaries, shareholders, officers, directors, employees, agents and representatives from any and all economic damage that results from Pharmacy providing Oncology Supply with materially incorrect information on this form or from failing to have in place an effective compliance program.

PHARMACY AUTHORIZED REPRESENTATIVE:

______________________________	______________________________
Name (Print)	Signature *(Digital signature accepted)*
______________________________	______________________________
Title	Date

I, as an authorized Oncology Supply 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.

Oncology Supply ASSOCIATE:

______________________________	______________________________
Name (Print)	Signature *(Digital signature accepted)*
______________________________	______________________________
Title	Date

*****IMPORTANT NOTE:** Both Oncology Supply associate and pharmacy authorized representative signatures MUST be present to initiate CSMP review.