DVMed supply

NEW ACCOUNT CHECKLIST FOR PHARMACY

- **Pharmacy Questionnaire**
  - **Must be complete**
  - **Must be legible**
- **Licenses**
  - **State Pharmacy Licenses** (Licenses must be to shipping address, and must be legible)
  - **Pharmacist in Charge**
  - **DEA Licenses**: Federal & State (where applicable)
  - **Seller's Permit** (if applicable)
  - **Reseller Certificate** (if applicable)
  - **Reseller Certificate** (if applicable)
- **Pictures of Pharmacy** (Please E-mail)
  - **Front of Building** (Must show signage with name of pharmacy)
  - **Front Door** (Must show hours of operation)
  - **Waiting Area**
  - **Dispensary**
  - **C-2 Safe/Vault Storage**
  - **Security System**
- **Photo ID** (Please scan & E-mail)
  - **Copy of photo ID of Pharmacist in charge**
  - **Copy of photo ID of Owner of Pharmacy**
- **Regulatory**
  - **Most recent Inspection Report from the Board of Pharmacy** (new pharmacy submit preliminary report)
- **Dispensing History** (Please E-mail)
  - **6-Month Drug/Prescription Dispensing Report**
    DUR Instructions- (Please submit dispensing computer generated report in MS Excel (XLS) & PDF Format. Separate non-control & controlled substance & sort in alphabetical order. Report must include: The pharmacy information, Drug Name, N.D.C., Strength, Package Size, Total Dispensed & Date Range)
- **Miscellaneous** (Upon Request)
  - **Copies of written Policies & Procedures**
  - **Resume of Pharmacist in Charge**
  - **Copy of Building Lease** (First Page & Signing Page)
  - **Corporate of State Business Documents providing Ownership information**
  - **Must be signed by Director of Pharmacy or Pharmacist in Charge**

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DVMed supply PHARMACY QUESTIONNAIRE

Please fill out completely. Questionnaires returned with blank spaces or unanswered questions will be returned for completion

Sale Rep:

Section 1: General Information

1. Referred by: _____

2. Pharmacy Legal Name & DBA (if any): _____

3. Pharmacy Address: _____
Street Name City State Zip Code

4. Billing Address: _____
Street Name City State Zip Code

5. Pharmacy Email & Web Address: _____

6. Pharmacy Phone Number: _____

7. Pharmacy Fax Number: _____

8. Purchaser Name & Phone Number: _____
Name Phone Number

9. Has the pharmacy ever operated under a different name? ☐ Yes ☐ No

If yes, what name(s)? _____

10. Full Name of Pharmacist in Charge: _____ Date of Employment: _____

11. Name of individual(s) who will sign Schedule II order forms: _____

12. Name of individual(s) who will place orders for Schedule III through V: _____

13. How do you store controlled substances?: ☐ Safe ☐ Locked Cabinet ☐ Dispersed with regular stock

14. Pharmacy opened (month/year): _____ / _____

15. Purchaser Hours: _____

16. Days Open: Monday: ☐ Tuesday: ☐ Wednesday: ☐ Thursday: ☐ Friday: ☐ Saturday: ☐ Sunday: ☐

17. Pharmacy's DEA registration number: _____ Exp. Date: _____

18. Authorized for following schedules: ☐ 2 ☐ 2N ☐ 3 ☐ 3N ☐ 4 ☐ 5

19. Registration Category: ☐ Retail ☐ Chain ☐ Central Fill Pharmacy ☐ Other: _____

20. Do you have a DEA registration as a Distributor: ☐ Yes ☐ No

21. State Board of Pharmacy License Number: _____ Exp. Date: _____

22. State Registration Category: ☐ Retail ☐ Chain ☐ Central Fill Pharmacy ☐ Other: _____

23. Provide details of any other applicable licenses and associated numbers: _____

24. Is the pharmacy a member of any professional organizations (NABP, NCPA, APHA, ETC.)?: ☐ Yes ☐ No

a) If yes, please list: _____

25. Does the pharmacy have any other certifications (VIPPS, ECT)?: ☐ Yes ☐ No

a) If yes, please list: _____

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Sale Rep:

26. When was the pharmacy last inspected & by whom? _____

a) Please attach a copy of the last inspection report & your responses.

Section 2: Ownership

27. Ownership Type: ☐ Sole Prop. ☐ Corp. ☐ Partnership ☐ LLC Other: _____

28. For corporations, indicated the state of incorporation: _____

29. Onwer(s) name (Corporate Officers if corporation): _____

30. Owner(s) Business Address: _____

31. Owner(s) Phone Number: _____

32. Owner(s) Fax: _____

33. Owner(s) Email: _____

34. Number of years owner has operated the pharmacy: _____

35. Are any of the owners not a licensed pharmacist? ☐ Yes ☐ No

36. Do any of the owners operate/own any other pharmacies? ☐ Yes ☐ No

a) If yes, provide the name & DEA number of the other pharmacy. Attach additional sheet if necessary: _____

_____

Section 3: History

37. Has the pharmacy ever had a DEA registration suspended or revoked? ☐ Yes ☐ No

a) If yes, provide details. Attach additional sheet if necessary: _____

38. Has the owner ever had a DEA registration suspended or revoked? ☐ Yes ☐ No

a) If yes, provide details. Attach additional sheet if necessary: _____

39. Has the pharmacist associate with the pharmacy ever been sanctioned by a regulatory agency? ☐ Yes ☐ No

a) If yes, provide details. Attach additional sheet if necessary: _____

40. Has the pharmacy ever had its state licenses suspended or revoked? ☐ Yes ☐ No

a) If yes, provide details. Attach additional sheet if necessary: _____

41. Do you conduct background checks on all employees? ☐ Yes ☐ No

42. Do you conduct drug screens of employees? ☐ Yes ☐ No

Section 4: Other Business Information

43. Is the pharmacy a closed door pharmacy? ☐ Yes ☐ No

44. Is the pharmacy located within a medical center? ☐ Yes ☐ No

45. Are you in close proximity to one or more medical facilities such as a hospital or large clinic?

Doctor's Offices : ☐ Yes ☐ No *Medical Clinics :* ☐ Yes ☐ No *Hospital:* ☐ Yes ☐ No

a) If yes, type, address, proximity to pharmacy: _____

_____

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Sale Rep:

46. Is the pharmacy affiliated with any other pharmacies? ☐ Yes ☐ No

a) If yes, please explain & list affiliates: _____

_____

47. Does the pharmacy have security guard(s) on the premises? ☐ Yes ☐ No

a) If yes, provide reason: _____

_____

48. How many prescriptions does the pharmacy fill on average daily basis? _____ N/A (New Pharmacy): ☐

a) What % of these prescriptions is for controlled substances? _____

b) What % of the controlled substance scripts are for Schedule II? _____

49. Are you filling any controlled prescriptions as an "online pharmacy"? ☐ Yes ☐ No

a) If yes, please furnish a copy of your DEA registration showing the modification that authorizes online pharmacy activity

b) Are you complying with all requirements of the Ryan Haight Act? ☐ Yes ☐ No

50. How does the pharmacy receive payments for products & in what approximate percentage? N/A (New Pharmacy): ☐

a) Insurance *% of Revenue:* _____

b) Medicare/Medicaid *% of Revenue:* _____

c) Cash/Credit/Debit Care *% of Revenue:* _____

d) Other: _____ *% of Revenue:* _____

51. Approximately how many prescriptions are filled for the following schedules on a weekly basis? N/A (New Pharmacy): ☐

a) Schedule II, IIN: _____

b) Schedule III, IIIN: _____

c) Schedule IIV: _____

d) Schedule V: _____

52. What percentage of the pharmacy's business is attributable to each of the following? N/A (New Pharmacy): ☐

Regular Customers: _____ % *Hospice:* _____ %

Long Term Care Facility: _____ % *Other:* _____ %

53. Does the pharmacy service pain management clinics? ☐ Yes ☐ No

a) If yes, list the following for each pain management clinic:

Name of Clinic	*Address of Clinic*	*Prescriber's Name*	*Prescriber's DEA #*

54. Does the pharmacy have any exclusive contracts, agreements, or arrangements with any particular practitioner, business group, investors etc. for filling Controlled Substance Prescriptions? ☐ Yes ☐ No

a) If yes, please explain: _____

55. Does the pharmacy supply, order for, or sell to any practitioners or other pharmacies? ☐ Yes ☐ No

56. Does the pharmacy offer a full range of sundries? ☐ Yes ☐ No

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Sale Rep:

Section 5: Miscellaneous Information

57. Does the pharmacy fill prescriptions for out-of-state patients? ☐ Yes ☐ No

a) If yes, please explain to what extent: _____

_____

58. Do you buy controlled drugs from other wholesalers: ☐ Yes ☐ No

59. Please provide names of all suppliers you have used within the last 24 months: N/A (New Pharmacy): ☐

Name of Supplier	*Non-Controlled RX* +	*Controlled RX* =	*Total*
	%	%	100%
	%	%	100%
	%	%	100%

60. Do you wish to order Controlled Substances on CSOS? ☐ Yes ☐ No

a) If yes, what email address do you want the password to be sent? _____

61. What procedures do you use to verify practitioners DEA & state board licenses? _____

_____

62. What procedures do you use to insure prescriptions are issued in normal course of a legitimate medical practice?

_____

_____

_____

63. Has the pharmacy ever refused to fill prescriptions for a particular practitioner? ☐ Yes ☐ No

a) If yes, why and whom? _____

_____

_____

64. Is the pharmacy comfortable with the prescribing practices of all of the practitioners for which it fills prescriptions? ☐ Yes ☐ No

65. Are the prescriptions written by physicians located in the state in which the patient reside? ☐ Yes ☐ No

66. Does the pharmacy use the state PDMP to aid in identifying and/or diversion of controlled substances? ☐ Yes ☐ No

67. Please list the 10 most frequents diagnoses of the patients receiving prescriptions for controlled substance.
(**WRITTEN DESCRIPTION ONLY - NO CODES**) N/A (New Pharmacy): ☐

1.	*6.*
2.	*7.*
3.	*8.*
4.	*9.*
5.	*10.*

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Sale Rep:

68. Are the conditions of the patients & diagnoses or treatment plans requested & maintained by the pharmacy? ☐ Yes ☐ No

a) If yes, how is this information stored & maintained? _____

_____

_____

b) If yes, is the pharmacy satisfied that the prescribed items are appropriate for treating the medical conditions of the patient & consistent with the patient's treatment plan? ☐ Yes ☐ No

69. Please provide the following information regarding the top 5 physicians that are writing the majority of the controlled substance prescriptions at your pharmacy: N/A (New Pharmacy): ☐

Doctor's Name	*DEA Registration #*	*State Medical License #*	*Practice Specialty*
1.			
2.			
3.			
4.			
5.			

Any changes in ownership, location, pharmacy or pharmacist-in-charge licenses shall be reported immediately to the staff at DV Medical Supply, Inc.

I declare under penalty of perjury that the foregoing is true and correct:

_____ _____ _____

Signature (DEA License Holder) *Title (DEA License Holder)* *Date*

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DEA DUE DILIGENCE FORM

This is <u>MANDATORY</u> if you will be purchasing Controlled Substances from DV Medical Supply, Inc.

DEA Registration Number _____ *DEA Registration Name* _____

DEA Registration Address _____ *City* _____ *State* _____ *Zip* _____

*PLEASE NOTE THAT DV MEDICAL SUPPLY WILL **ONLY** SHIP CONTROLLED SUBSTANCES TO THE **EXACT** ADDRESS LISTED ON THE DEA LICENSE. **<u>NO EXCEPTIONS.</u>**

The Customer agrees that it will abide by all applicable laws, rules, regulations, ordinances and guidance of the federal Drug Enforcement Administration (DEA), the United States Food and Drug Administration (FDA), and the state into which it distributes controlled substances and the state in which it is licensed. Further, Customer agrees that it will not distribute controlled substances if it suspects these drugs will not be used for a legitimate medical purpose or in the normal course of professional practice.

In addition, Customer agrees that it understands that DV Medical Supply is required by DEA regulations to report to the local DEA Diversion field office any instances of suspicious orders of controlled substances pursuant to DEA guidelines. To this end, Customer will provide to DV Medical Supply any information regarding its distribution of controlled substances which DV Medical Supply may need to evaluate compliance with DEA regulations. DV Medical Supply reserves the right in all cases to limit or eliminate any sales of controlled substances to customers in any situation which it determines in its sole discretion pose issues or questions of proper usage and/or adequate legal compliance by the Customer.

Customer agrees to monitor itself and be alert to the proper usage of controlled drugs distributed by it, and to exercise due diligence to ensure the legal compliance by its prescribers and patients with applicable laws and regulatory guidelines. Customer is expected to exercise its professional knowledge and expertise to keep current on all such legal and regulatory guidelines. Customer acknowledges that DV Medical Supply may provide a copy of this agreement to the DEA, other federal regulatory agencies, state regulatory agencies, or state licensing boards when determined to be appropriate.

Customer agrees that failure to comply with this agreement may result in the termination of the relationship between DV Medical Supply and Customer, in whole or in part, notwithstanding any other agreements to the contrary.

Agreed to by a duly authorized officer, partner, or principal of Customer:

_____
Signature (DEA License Holder)

Print Name _____ *Title* _____ *Date* _____

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ACCOUNT TERMS & CONDITIONS

Credit Card payments is due prior to shipment

Customer agrees to jurisdiction & venue in Los Angeles, California for all disputes relating to or arising from the purchase of products from DV Medical Supply, Inc.

Quotation & pricing are subject to change based on the availability of products, as well as price fluctuations by vendors of DV Medical Supply, Inc. All special orders are non-refundable & non-returnable upon placing the Purchase Order.

In the event there is a shortage or discrepancy found after delivery of products, customer agrees to notify vendor within 48 hours of receipt of goods. After the 48 hours period, customer waives any & all claims with regards to such shortage or discrepancy & agrees to pay invoice in full.

Customer agrees that all sales are final & that goods received are non-returnable.

Should any provision herein be determined to be void, invalid, unenforceable or illegal by a court, the validity & enforceability of the other provisions shall not be affected thereby.

We reserve the right to refuse to do business with anyone including, but not limited to, the following: those who do not possess a valid home state license or DEA registration (if applicable), those that have had prior convictions, or those no found to be in good standing with their licensing board.

By submitting this application the undersigned acknowledges that the information provided is accurate & true to the best of their knowledge & agrees to receive faxes and/or emails to the above-listed contact.

The undersigned affirms & represents that they are authorized to execute these “Term & Conditions” on behalf of this customer.

_____ _____

Signature *Date*

_____ _____

Name (Print) *Title*

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CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel the authorization at any time by contacting us. This authorization will remain in effect until cancelled.

CREDIT CARD INFORMATION

Card Type: ☐ **MasterCard** ☐ **VISA** ☐ **AMEX** ☐ **Discover** ☐ **Other:** _____

Cardholder Name (as shown on the card): _____

Corporate Card: ☐ **Yes** ☐ **No**

Card Number: _____

CVV Code: _____

Expiration Date: _____ / _____
Month Year

Billing Address: _____
Street Name City State Zip Code

Cardholder Phone Number: _____

I,_____ , authorize DV Medical Supply, Inc. to charge my credit card above for the agreed upon purchases. I Understand that my information will be saved on file for future transactions on my account.

_____ _____
Credit Card Holder's Signature *Date*

_____ _____
Name (Print) *Title*

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SUSPICIOUS ORDER MONITORING PROTOCOL

Revised January 2017 - In compliance with 21 CFR 1301.74(b)

DV Medical monitors customers engaged in dispensing controlled substance for one or more of the following characteristics in the pattern of ordering controlled substances:

1. Ordering excessive quantities of a limited variety of controlled drug (e.g. ordering only Oxycodone, Hydrocodone, & Alprazolam) while ordering few, if any, non-controlled drugs.
2. Ordering a limited variety of controlled substances in quantities disproportionate to the quantity of non-controlled drugs ordered.
3. Ordering excessive quantities of a limited variety of controlled substances in combination with excessive quantities of lifestyle drugs.
4. Ordering controlled substances with unusual frequency.
5. Ordering the same controlled substance from multiple distributors.
6. The percentage of the customer's business which dispensing controlled substances constitutes.
7. Compliance with the laws of every state in which it is dispensing.
8. Association with pain clinics.
9. Soliciting buyers of controlled substances via internet or being associated with an internet site which solicits orders for controlled substances.
10. Offering to facilitate acquisition of a controlled substance from a practitioner with whom the buyer has no pre-existing relationship.
11. Filling the prescriptions issued by practitioners based solely on a questionnaire & without a medical examination or valid doctor/patient relationship.

To ensure customer compliance, DV Medical Supply:

1. Conducts random site visits to visually evaluate business practices.
2. Verifies licensor is in good standing prior to shipment of controlled drugs.
3. Randomly request usage report, reviews forms, and/or any necessary information to evaluate order requests.
4. Restricts controlled substance order to be a maximum of 20% of the total prescription order.
5. Implements monthly allotment of controlled drugs based on usage report.

I have read & understand the protocol for DV Medical's suspicious order monitoring.

_____ _____

Signature *Date*

_____ _____

Name (Print) *Title*

NOTE: THE SUSPICIOUS ORDERING PROTOCOL THAT WE HAVE ADOPTED REFLECTS THE UNSTABLE NATIONAL CONTROLLED SUBSTANCE ABUSE PROBLEMS. OUR POLICY IS SUBJECT TO CHANGE.

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