INDEPENDENT PHARMACEUTICAL

854 E Crescentville Rd
West Chester, Ohio 45246
Phone 888-258-5036
Fax 844-668-8628

RETAIL PHARMACY QUESTIONNAIRE

Pharmacy Information

Pharmacy name: _____ Account Code: _____

DBA: _____ **Number of**

Address: _____ Years In business: _____ Employees: _____

Business hours: _____ Phone: _____

Owner's Name: _____ Buyer's Name: _____

Pharmacy License #: _____ DEA License #: _____

1. List Pharmacists at this location: Name: _____ License # _____

Name: _____ License # _____

Name: _____ License # _____

Attach a sheet for additional Names. Name: _____ License # _____

2. Have any of these pharmacists or the pharmacy ever been sanctioned/disciplined in the state(s) licensed?

Y ( ) No ( ) If Yes please give details: _____

3. Is this pharmacy affiliated with any other pharmacy? Yes ( ) No ( )

If yes please provide Name and Address: _____

4. Date of most recent

Board of Pharmacy Inspection: _____ DEA Inspection: _____

Attach copies of inspection(s) when returning questionnaire.

5. Has the pharmacy ever had a State or DEA registration suspended or revoked? Yes ( ) No ( )

If yes please explain: _____

6. Has the owner ever had a State or DEA registration suspended or revoked? Yes ( ) No ( )

If yes please explain: _____

7. Does the pharmacy have other Licensures/Registrations (re-packager, wholesaler etc.)? Yes ( ) No ( )

If yes please list and provide copies of each: _____

Business Activities

1. Please provide a percentage of the pharmacy's business activities (totals 100%)

% Retail: _____ % Long Term Care: _____ % Hospice/Pain Management: _____

% Infusion: _____ % Compounding: _____ % Other: _____

2. Please provide a percentage for the manner in which the pharmacy receives business (totals 100%)

% walk in _____ % Phone _____ % Fax _____

% Mail Order (please explain) _____

% Internet (please explain) _____

3. How many prescriptions does the pharmacy fill daily? _____

4. Are prescriptions written by prescribers located in the state the patient resides? Yes ( ) No ( )

If No, which states?

Controlled Substances

1. List the states into which the pharmacy dispenses **controlled substances:** _____

2. Does your state have a way to check if a patient is prescriber/pharmacy shopping? Yes ( ) No ( )

If Yes, Name: _____ Do you utilize this? Yes ( ) No ( )

3. Do you have a Security System that monitors controlled substances in your facility? Yes ( ) No ( )

If yes, please describe the System: _____

4. List your top THREE prescribers for **CONTROLLED SUBSTANCES**:

Prescriber Name:	**DEA Number:**

5. Has the pharmacy ever been refused **controlled substance** orders by any other distributor or wholesaler?

Yes ( ) No ( ) If yes, please explain: _____

6. Has your pharmacy ever refused to dispense a prescription to a customer? Yes ( ) No ( )

If No please explain: _____

7. Does your pharmacy have, or are you affiliated with a web site? Yes ( ) No ( )

If Yes, please provide web addresses: _____

8. Please provide types of payments the pharmacy received for **controlled substances** and the approximate percentage of total payments (totaling 100%):

Private Insurance _____% Medicare/Medicaid _____% Cash _____%

9. If purchasing CII's, provide a **3 month dispensing report & list all *Authorized Signers of 222 forms*** below*:*

Comments:

Signature and Title: _____ Date: _____

****

Internal Signatures

Account Manager - Date	Compliance - Date	Management - Date