 FORM MR.13-005B

  **MEDMAX CUSTOMER CONTROLLED SUBSTANCE APPLICATION**

# This application is for reviewing your eligibility for purchasing controlled substances from MedMax Rx. Your current and accurate 90-day drug utilization review (DUR) in excel format, denoting controlled vs. non-controlled substances for all drugs must be submitted with this application. In lieu of an initial on-site visit, please include photos of your controlled substance storage area. After a MedMax due diligence review, you will be notified if approved for CS purchases.

# Please email compliance@medmaxrx.com with all documentation.

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| --- |
| **Principal’s/Officer’s Contact Information**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Company Information** Legal Name: xxx\_\_\_\_\_ Trade Name (dba): \_\_\_\_\_\_xxx\_\_\_\_\_\_\_\_\_\_\_ Ship To Address:\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_ \_\_\_\_\_\_St: \_\_\_\_Zip: \_\_\_\_\_\_\_ Tel. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Business Type (Circle one): Pharmacy – Medical - Wholesale – Virtual - Other: \_\_\_\_\_\_\_\_\_\_\_\_ DEA Registration #: \_\_\_\_\_\_\_\_\_\_\_xxx\_\_ Exp. Date: \_\_\_\_\_\_\_\_\_\_\_\_ Schedules: \_\_\_\_\_\_\_\_\_\_\_\_ State License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_ Exp. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State CS Permit #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Contact/Designated Representative Information** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Banking and Business Reference**Bank: Account #: City: ST: Tel: Bus. Ref. (1): Tel.:  |

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#  Controlled Substance Questionnaire

**The following questionnaire is to validate and to attest that your company, has not engaged in, nor shall ever engage, in conducting business as an internet pharmacy or internet supplier of controlled substances. All medication is only dispensed to patients who have been evaluated face-to-face by a licensed and authorized medical provider. Your company declares and attests that it fully complies with all federal and state laws and regulations on the dispensing of both non-controlled and controlled substances. MedMax Rx is committed to ‘Knowing its Customers’, monitoring its customer’s orders, and complying with DEA and State regulations; including the reporting of orders deemed suspicious. MedMax has the right to question, limit, and/or refuse to fill any controlled substance order.**

1. What is the pharmacy or practice percentage of drug dispensing business? (Equal 100% for each side)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Walk-in | Phone/Fax | Mail Order | Internet |  | Cash | Credit | Insurance |
|  |  |  |  |  |  |  |  |

1. What percent of your drug prescription business is for controlled substances? \_\_\_\_
2. What percent of your prescriptions for controlled substances come from pain clinics? \_\_\_\_\_
3. How many total prescriptions does your pharmacy/practice fill monthly? \_\_\_\_\_\_
4. What was the date of your last state inspection (include copy of report)? \_\_\_\_\_\_\_\_\_\_\_\_\_
5. What was the date of your last federal inspection (include copy of report)? \_\_\_\_\_\_\_\_\_\_\_\_
6. Has the owner or pharmacy/practice ever had a DEA registration suspended or revoked? YES or NO

 If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has your pharmacy/practice ever operated under a different name? If ‘no’ state ‘no’. If yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does your pharmacy/practice have a website? \_\_\_\_\_\_ If yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. List your top 5 practitioners and their DEA #’s that write prescriptions for controlled substances being

 filled by your pharmacy?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List your top 5 suppliers and their DEA #’s that your pharmacy/practice purchases controlled

 substances from?

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1. Any exceptions/circumstances where the pharmacy or practice does not follow procedures to verify

 prescriptions and validate a bona-fide doctor-patient relationship? If ‘no’, state ‘no’\_\_\_\_\_\_

If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Any exceptions/circumstances where the policies and procedures set by the pharmacy/practice to

 prevent the diversion of any medication by employees/patients/others are not used? YES or NO

 If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the pharmacy/practice fill prescriptions for patients who are not domiciled in the state of the

 practitioner? YES or NO If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the pharmacy/practice report to all States, if required, that have a prescription drug monitoring

 program (PDMP) in which your customers reside and/or to whom to dispense or ship to? YES or NO

 If no, provide specifics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are the owners or officers of your business affiliated with, or a division of, any other pharmacy,

 wholesale drug distributor or medical practice? YES or NO If yes, provide specifics below:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has any corporate officer/owner/employee of the pharmacy/practice ever been charged, convicted,

 plead no contest or had adjudication withheld on any charge involving possession, use or distribution

 of controlled substances under the Federal Controlled Substances Act or any state laws pertaining to

 controlled substances? YES or NO If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List names of authorized signers of DEA Form 222 and/or holders of CSOS certificates (C.F.R 1205.05):

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Attestation and Agreement

I/We hereby attest, as an officer or agent of applicant, that all information in this application is

current, complete and accurate. This information has been furnished with the understanding that it will be used to determine the legitimacy and compliance of the applicant’s business and its owners/officers. Applicant will inform MedMax Rx of any future material changes to the information submitted on this controlled substance application.

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

Please email application and supporting documents (90 Day DUR and photos of CS storage area) as an attachment to compliance@medmaxrx.com.

If any questions, please email at address above or call MedMax Rx at 1-844-777-4700.