2950 BROTHER BLVD
BARTLETT, TN 38133
Phone: 1-800-542-8677
Fax: 901-531-1725

Know Your Customer Questionnaire

Clear Form | Print Form

Pharmacy Questionnaire

SECTION I GENERAL INFORMATION

Primary DEA #: _____ Is the primary DEA # linked to a physician or practitioner? **Yes** ◯ **No** ◯

Name of Pharmacy: _____ Phone: _____

DBA (if applicable): _____ Fax: _____

Address: _____ City: _____

State: _____ Zip: _____ Pharmacy e-mail: _____

State License #: _____ State Controlled Substance License # (if applicable): _____

Owner's Name: _____

Number of Employees: _____ Business Hours: _____

Number of Years in Business: _____ Pharmacy Website (if applicable): _____

Number of Years Under Current Ownership: _____

Please check the controlled substance schedules of drugs that this pharmacy intends to purchase from TopRx:

Schedule II ☐ **Schedule III** ☐ **Schedule IV** ☐ **Schedule V** ☐ **None of these** ☐

SECTION II PHARMACY PROFILE INFORMATION

1. Has the pharmacy ever been disciplined or had their DEA registration, state license/permit, or state controlled substance permit suspended or revoked? (For existing customers, since the last questionnaire was submitted?)
   Yes ◯ **No** ◯ If you answered "**Yes**", please attach documentation explaining the event.
2. On average, how many **total prescriptions** are filled daily? _____
3. On average, what percentage of these prescriptions are for **controlled substances**? _____
4. Please indicate the percentage of prescriptions filled, by customer? The percentages must total 100%.

Physician Offices	_____ %	Hospices	_____ %
Rehab Centers	_____ %	Pain Clinics	_____ %
Hospitals	_____ %	Other (list below)	_____ %
Diet Clinics	_____ %	_____	
Nursing Homes	_____ %	**Total**	_____ %

5. Is this a closed door pharmacy (*no retail business*)? **Yes** ◯ **No** ◯
6. Is this pharmacy related to any additional locations? **Yes** ◯ **No** ◯ If you answered "**Yes**", how many? _____
   If you answered "**Yes**", Please list the name and address of each pharmacy.

Address:	City:	State:	Zip:
Address:	City:	State:	Zip:
Address:	City:	State:	Zip:
Address:	City:	State:	Zip:
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7. What process is used to validate a prescription before it is dispensed to the patient?

_____

_____

8. What percentage of controlled substances are paid for in cash monthly: _____ % (Include only prescriptions paid-in-full by the patient using their own cash, credit card, debit card or check. Do not include insurance co-pays.)

SECTION III PURCHASING INFORMATION

1. Other than TopRx, please list the pharmaceutical wholesale drug distributors this pharmacy intends to use in the next 6 months.

   Primary: _____ Secondary: _____

   Tertiary: _____

2. Have any previous wholesalers suspended or restricted purchases of controlled substances to the pharmacy citing of concerns identified by their Order Monitoring program? **Yes** ◯ **No** ◯

3. Please list the names of up to three Authorized Buyers for this pharmacy.

Authorized Buyers

SECTION IV PHARMACY STAFF INFORMATION

1. Please list up to three licensed individuals at the pharmacy and their state license numbers. Please state the names exactly as they appear on their license.

Staff Member's Name	State License #	Authorized to Sign DEA 222 Forms	
		Yes	No
		◯	◯
		◯	◯
		◯	◯

2. Has any licensed individual working at the pharmacy ever had their DEA registration, state permit, or state controlled substance permit suspended, revoked or disciplined? (For existing customers, since the last questionnaire was submitted?) **Yes** ◯ **No** ◯ *If you answered "Yes", please attach documentation explaining the event.*

3. Please provide the name, phone number and e-mail address of the person to contact if Top Rx has any questions regarding the responses on this questionnaire,

   Name: _____ Phone: _____ e-mail: _____

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SECTION V PHYSICIAN INFORMATION

1. Please list the names and their corresponding DEA # of the top five (5) physicians who write prescriptions for controlled substances dispensed by this pharmacy.

	Physician's Name	DEA #
1.		
2.		
3.		
4.		
5.		

SECTION VI INTERNET AND MAIL ORDERS

1. Does this pharmacy fill new prescriptions received via the internet? **Yes** ◯ **No** ◯ (If you answered "**No**", please skip to question 3.) Rx's filled via E-Script do NOT count towards internet sales.
2. Is this pharmacy VIPPS certified? **Yes** ◯ **No** ◯
3. Is this pharmacy required to obtain a modified DEA registration # under the Ryan-Haight Act of 2008? **Yes** ◯ **No** ◯
4. Does this pharmacy advertise on the internet or send unsolicited e-mail that directs persons to a website through which a controlled substance or a prescription for a controlled substance may be purchased? **Yes** ◯ **No** ◯
5. Please list any Internet site(s) with which this pharmacy is associated in the space below.

   _____
6. Does this pharmacy participate in any form of mail order sales of drugs, (controlled and/or non-controlled substances)? **Yes** ◯ **No** ◯ (If you answered "**Yes**" please attach a copy of this pharmacy's license(s) which authorize the shipment of drugs within each applicable state.)

SECTION VII LICENSING AND REGULATIONS

1. What was the date of the pharmacy's last state inspection (mm/dd/yy)? _____ (Please attach a copy of the report.) If you cannot attach a copy, please indicate why:

   Never Inspected ◯ **Copy not provided** ◯ **Not required to retain** ◯ **Not on property** ◯ **Unable to locate** ◯ **Other (Explain)** ◯ _____
2. What was the date of the pharmacy's last federal inspection (mm/dd/yy)? _____ ? (Please attach a copy of the report) If you cannot attach a copy, please indicate why:

   Never Inspected ◯ **Copy not provided** ◯ **Not required to retain** ◯ **Not on property** ◯ **Unable to locate** ◯ **Other (Explain)** ◯ _____
3. Is this pharmacy in compliance with all controlled substance rules and regulations within the states it serves, including all reporting requirements? **Yes** ◯ **No** ◯
4. Please list all the states where this pharmacy dispenses controlled substances:

   _____

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SECTION VIII COMPLIANCE REPRESENTATIONS & WARRANTIES FOR PHARMACY CUSTOMERS

_____ ("Customer") agrees and warrants 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), the states into which it dispenses controlled substances and the states in which it is licensed. Further, Customer agrees that it will not dispense controlled substances if it suspects that a prescription is not issued for a legitimate medical purpose or in the normal course of professional practice.

In addition, Customer agrees to and understands that TopRx, LLC 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 agrees that it will be alert for red flags of suspicious orders, including, but not limited to:

1. Numerous controlled substance prescriptions written for the same drugs, in the same quantities for the same time period by the same or different prescribers or group of prescribers for the same patient;
2. Numerous controlled substance prescriptions written for the same person or several persons by the same prescriber or group of prescribers;
3. Numerous prescriptions written for the same patient by prescribers located in different states than the patient;
4. Numerous prescriptions written by local prescribers for patients located in different states.

Customer agrees that if any of the above-noted or other red flags exist, it is prudent to contact the prescriber to validate the legitimacy of the prescription and/or to discontinue filling prescriptions from the prescriber, group of prescribers or customer in question. In addition, the pharmacist should contact the State Board of Pharmacy or the local DEA Diversion Field Office (See Appendix N, DEA Pharmacists Manual, (latest edition).

TopRx reserves the right, at our sole discretion, to limit or eliminate the sales of controlled substances to any customer.

Customer agrees to monitor itself and to be alert to the proper usage of controlled drugs dispensed 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 applicable laws and regulatory guidelines.

Customer acknowledges that TopRx may provide a copy of this agreement to the DEA, other federal regulatory agencies, state regulatory agencies, or state licensing boards upon their request or when determined by Top Rx to be appropriate.

Customer agrees that failure to comply with this Agreement may result in the termination of the relationship between Top Rx and Customer, in whole or in part, notwithstanding any other agreements to the contrary.

By submitting this form with this box checked, ☐ I am certifying that the above is agreed to and warranted by a duly authorized officer, partner or principal of Customer. Additionally, I certify that the information provided on, and in connection with, this questionnaire is true, accurate and complete. Lastly, I understand and agree to indemnify and hold TopRx harmless of any regulatory or legal action that results from knowingly providing false or deliberately omitting relevant information on and in connection with this document.

Full Name (print): _____ Date: _____

Title: _____

E-mail address of person completing this form: _____