INDEPENDENT PHARMACEUTICAL

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# 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 _____%

Comments: _____

Signature and Title: _____ Date: _____

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*Internal Signatures:*

| Account Manager - Date | Compliance - Date | Management - Date |
|---|---|---|
| | | |