

HOSPITAL INFORMATION FORM

Please complete the information form and provide electronic files where appropriate. All items must be completed. If an item is not specific to your business, please mark with N/A. In order to process your order, please include a copy of your state-issued license(s) and your DEA registration with this information form.

1. Are you a current or new customer? Current ____ New ____

2. Provide the name/title of person from Hospital/Surgery center providing this information.
Name: _____ Title: _____
Address: _____ Website: _____
Phone number: _____ Fax number: _____

3. Primary DEA# _____

4. Is the facility name different from the corporate name? (dba: doing business as)
Yes ____ No ____
If yes, please provide the name: _____

5. Has the hospital ever operated under a different name? Yes ____ No ____
If yes, please provide the name: _____

6. Is your hospital a member of a GPO? Yes ____ No ____
If yes, name of group/organization: _____

7. Ownership type: Sole Proprietor ____
Non-Profit Organization ____
(Name state of incorporation: _____)
For-profit Organization: _____
Partnership: _____
Other: _____

8. Names of the top 4 officers of the Hospitals/Surgery-Centers (e.g., CEO, president, vice president(s), secretary, treasurer) and the person(s) responsible for the Hospitals/Surgery-Center's pharmacy operations. If a partnership or sole proprietor, list names of partners or owner(s).

Name	Title
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

PRIOR HISTORY

9. Have any of the DEA registrants (pharmacies, physicians, dentists, etc.) associated with the Hospitals/Surgery Centers and acquiring drugs based on their DEA license ever had a DEA registration, state permit (pharmacy), or state controlled substance permit suspended, revoked or disciplined?

Yes ___ No ___

If yes, please provide DEA registrant number and current status.

10. Have any of the Pharmacists-in-Charge (PIC) working in your pharmacies ever had his/her license(s) suspended, revoked or disciplined? Yes ___ No ___

If yes, Please supply their license number and the location (State) the action occurred.

BUSINESS INFORMATION:

11. Please identify all the pharmaceutical distributors your organization uses to purchase controlled substances:

Name: _____ Primary ___ Secondary ___ Tertiary ___

Name: _____ Primary ___ Secondary ___ Tertiary ___

Name: _____ Primary ___ Secondary ___ Tertiary ___

12. Does your organization purchase any controlled substances directly from manufacturers?

Yes ___ No ___

13. Does your organization fill new prescriptions or sell pharmaceuticals via the internet?

Yes ___ No ___

If yes, provide the following:

Name of website:

Address or URL address:

14. Is the pharmacy department managed by an outside organization? (i.e., Cardinal Health, McKesson, or other provider?) Yes ___ No ___

Management group name: _____

Role of provider:

Management only ___ management and staff ___ Staff only ___

15. Please indicate the approximate percentage of prescription orders your pharmacies receive in the following areas:

Inpatient patient orders _____%

Employee prescriptions _____%

Outpatient patient orders (not employee) _____%

Other: _____%

16. Do you do any cash transactions outside of the patient bill? Yes___ No___

17. What approximate percentage of the revenue? _____%

PHARMACEUTICAL NEEDS

18. Of your products purchased, please indicate what percentages of these products are injectable controlled substances orders. (check all that apply)?

OTC___

Prescription___

Controlled Substance___ % Injectables ___ % non-injectables___

List 1 Chemical___

Other: _____

19. List Top 5 controlled substances dispensed or administered for any one month (in terms of dosage units)

1.

2.

3.

4.

5.

20. Do you order any of these products? (Check all that apply)

Hydrocodone ___

Alprazolam ___

Oxycodone ___

None of these ___

21. If so, what is the approximate combined percentage of these products compared to your total controlled drug usage/month?

0-25% of total ___ 26%-50% of total___

51%-75% of total___ 76%-100% of total ___

22. On average, how many dosage units are dispensed or administered monthly?

Hydrocodone units___%

Alprazolam units ___%

Oxycodone units ___%

23. What is your average daily census (ADC) and/or your average surgery case load/month?

Average Daily Census _____ Average Daily Case Load/Monthly _____

24. Do you provide any of these specialty services?
Oncology ____
Hospice ____
Pain Management Clinic ____
Other (please specify): _____
25. Do you anticipate an increase or decrease in utilization or change in specialized services offered?
If yes:
Type of service added/changed: _____
Approximate date of change: _____
26. What is the usual procurement pattern for controlled substances?
Daily as needed ____
Weekly as needed ____
Monthly as needed ____

SYSTEMIC ANTI DIVERSION PROCESSES/PERSONNEL

27. List (or provide an electronic file to GMB-SPS-KYCHospitals@Cordlogistics.com) of all names, addresses, and DEA numbers for those pharmacies/entities (that receive drugs) operated by your Hospital/Surgery Center, if applicable.
28. Please fax or email a copy of your controlled substance management policies to: 614-553-9252 or email: GMB-SPS-KYCHospitals@Cordlogistics.com or describe in detail below:

29. Controlled Substance Usage Analysis - How often does your facility review controlled drug usage reports?

Daily ___ Weekly___ Montly___ Other:_____

30. Systems--Please describe systems that support order management, inventory control, and any other system that controls/monitors/tracks usage and supply chain.

Controlled Inventory Management (Pyxis CII Safe or other management system)___

Manual System (with routine audits)___

Other: (please describe)_____

31. Organizational contact - please provide a key person our distribution center may contact regarding anti-diversion activities or threshold events.

Contact name:_____

Title_____

Phone_____

Email_____

32. CII buyer name:_____

Phone:_____

Email:_____

Fax:_____

Preferred means of contact for order status updates_____