Controlled Substance Application

Pharmacy Name: _____

Pharmacy Address: _____

City, State, Zip: _____

Telephone Number: _____

Preferred Email: _____

Type of business:

- ☐ Pharmacy
- ☐ Hospital
- ☐ Hospice/Infusion Service
- ☐ Pain Management Clinic
- ☐ Manufacturer
- ☐ Medical Clinic
- ☐ Veterinary Clinic
- ☐ Other _____

1. Is the pharmacy licensed and complying with all laws/regulations in all states for which it mails or fills prescriptions? ☐ Yes ☐ No
2. Does the pharmacy have a written diversion policy/procedure in place that includes a suspicious order monitoring program? ☐ Yes ☐ No
3. What is the pharmacy's ratio of controlled vs. non-controlled orders?

   Controlled _____ % vs. Non-controlled _____ %

4. Who is the pharmacy's primary supplier of controlled substances?

   _____

5. If the pharmacy fills prescriptions for Pain Management or other specialty practitioners (diet, oncology, etc.), is the pharmacist comfortable with the prescribing practices of the practitioner?

   ☐ Yes ☐ No

6. Has the pharmacist questioned or been uncomfortable with, the prescribing practices of any practitioner?

   ☐ Yes ☐ No

7. Has the pharmacy ever refused to fill prescriptions for a practitioner? ☐ Yes ☐ No

   If so, why and who? _____

8. Are there particular practitioners who constitute most of the prescriptions it fills?

   ☐ Yes ☐ No

Triova Pharmaceuticals, LLC 115 W. 3rd Street, Suite 720 Tulsa, OK 74103 (539) 777-0720

9. If yes, who are the practitioners (Name and DEA registration number)?

_____
_____
_____

ATTACH A COPY OF THE PHARMACY'S STATE BOARD LICENSE, DEA REGISTRATION AND SALES TAX PERMIT (if applicable) if not already on file with Triova Pharmaceuticals.

Application completed by: (print)_____

Application completed by: (sign)_____