



Travis County Commissioners Court Agenda Request

Meeting Date: Tuesday, September 16, 2014

Prepared By/Phone Number: Sydney Ceder, (512)854-9882

Elected/Appointed Official/Dept. Head: Cyd Grimes

Commissioners Court Sponsor: Judge Biscoe

Agenda Language: Authorize Casey Ping, STAR Flight Program Director, to sign Declaration of Eligibility for Contract Pricing for AmerisourceBergen and any other pharmaceutical manufacturer that may become available.

- **Purchasing Recommendation and Comments:** Purchasing concurs with department and recommends approval of requested action. This procurement action meets the compliance requirements as outlined by the statutes.

On April 15, 2008, Commissioner's Court approved Premier Purchasing Partners as the Group Purchasing Organization (GPO) for the County. As a result, declarations were required to establish the relationship between the GPO and pharmaceutical manufacturers to allow the County to access Premier's contract prices for both brand name and generic pharmaceuticals.

On April 22, 2008, Commissioner's Court approved the request to authorize Diana C. Gonzalez, RPh, Director of the Travis County Jail System Pharmacy, to sign declarations on behalf of the Travis County Jail System Pharmacy.

STAR Flight recommends approval of the Declaration of Eligibility form for AmerisourceBergen and requests authorization for Casey Ping, STAR Flight Program Director, to sign the Declaration of Eligibility for AmerisourceBergen and any other pharmaceutical manufacturers that may become available. A copy of the signed forms will be forwarded for the Purchasing Office file.

Form will not be processed unless all questions are completed

Office Use Only

Name of BDM or Account Manager: _____

Phone of BMD or Account Manager: _____

Servicing Distributions Center(s) _____

This questionnaire is to be completed by the Owner and Business Development Manager during an on-site visit

1. Pharmacy Name: _____
- a. ABC Account number (Legacy) _____
 - b. Pharmacy's dba (doing business as), if any _____
 - c. Has the pharmacy ever operated under a different name?
Yes ___ No ___ If yes, provide the Name: _____
 - d. Will ABC be this customer's primary wholesaler? Yes ___ No ___
 - e. Has this customer signed a Prime Vendor agreement? Yes ___ No ___
 - f. Does this customer have a PVA or equivalent with any other wholesaler?
Yes ___ No ___ If yes, name _____

2. Pharmacy Address: **Dell Childrens Medical Center / STAR Flight Quarters**

- a. Street: **4900 Mueller Blvd**
- b. City: **Austin**
- c. State: **TX**
- d. Zip: **78723**

3. Pharmacy Phone Number: _____ Fax Number: _____

4. Pharmacy Email Address: _____

5. Check one:

- Start-up business. Other suppliers _____
- Existing business adding or changing suppliers. _____
Estimated monthly dollar volume _____
Identify any secondary suppliers customer intends to utilize. _____
Identify prior suppliers _____
Has a supplier ever suspended or ceased controlled substance sales to the pharmacy? ___ Yes ___ No
If yes, why _____
- Existing ABC Customer. Account # _____

6. Name of pharmacist –in –charge (PIC) as it appears on the license

7. PIC's state license number: _____

8. Has the PIC ever been sanctioned/disciplined in any state(s) where they are or have been licensed?
Yes ___ No ___ If Yes, give details (when, why, etc.)

9. Is this pharmacy affiliated with any other pharmacy?
Yes ___ No ___ If yes, provide the following:

Name: _____
Address: _____
Phone Number: _____ Fax Number: _____

Note: If there are additional affiliates please attach an additional sheet with the information

10. Ownership type: Check one
a. Sole Proprietor ___ Corporation ___ Partnership ___ Other _____ (describe)
b. If corporation, provide name of CEO _____

11. Owner(s) name: _____

12. Owner State of Residence: _____

13. Owner Phone Number: _____ Fax Number: _____

14. Owner Email Address: _____

15. Number of years owner has operated pharmacy _____

16. Is the Owner a licensed pharmacist?
Yes ___ No ___

17. Pharmacy DEA registration #: MT2632253

18. State BOP license # _____

19. What is the pharmacy's Self-Certification number which is required to sell pseudoephedrine products?
_____ (refer to: <http://www.deadiversion.usdoj.gov/meth/index.html#sales>)

20. Has the Pharmacy ever had a DEA registration or State license/registration suspended or revoked? Yes ___ No X
If so, give details (when, why, etc.)

21. Has the Owner, family member, or any employee of the pharmacy ever had a DEA registration or State license/registration suspended or revoked?
Yes ___ No X If so, give details (when, why, etc.)

22. Does the pharmacy have any other licensure/registration (wholesale, repackager, etc...)?
Yes ___ No ___ If so, provide copies.

23. Check the following manners of receiving business and provide what percentage of the total business it comprises:

Walk-In	Yes ___	No ___	___%
Phone	Yes ___	No ___	___%
Fax	Yes ___	No ___	___%
Internet/Mail Order/E-Scribe	Yes ___	No ___	___%

24. Which state(s) does the pharmacy ship into (if any)? _____

25. Is the pharmacy licensed for sales in all states it distributes to?

Yes ___ No ___

26. Are all prescriptions written by physicians located in the state in which the patient resides?

Yes ___ No ___

27. Does the pharmacy have written policies and procedures regarding the filling of prescriptions?

___ Yes ___ No If yes, information may be required to be produced upon request

a. How many prescriptions are filled daily _____; monthly _____?

b. Percentage of prescriptions that are controlled substances _____ %

c. Verification process _____

d. Does the pharmacy use the State Rx monitoring program? ___ Yes ___ No ___ N/A

e. Does the pharmacy verify the physician's state license and/or DEA registration? ___ Yes ___ No

f. Does the pharmacy engage in discussions with prescribing physicians? ___ Yes ___ No If yes, how documented? _____

g. What is the pharmacy's procedure for reporting fraudulent Rx's? _____

28. Check the following types of products and provide the approximate percentage of products you expect to purchase from AmerisourceBergen?

HBA/OTC	Yes ___	No ___	% of total purchases
Non-Controlled Rx	Yes ___	No ___	% of total purchases
Controlled Substances	Yes <input checked="" type="checkbox"/>	No 100	% of total purchases
Listed Chemicals	Yes ___	No ___	% of total purchases

29. Anticipated or actual usage of certain controlled substances:

Item	Monthly Usage Values in # of tabs	Average Tablets per Prescription	Average Days Supply per Prescription
Oxycodone Products			
Oxycodone 30 mg IR			
Hydrocodone			
Alprazolam			
Carisoprodol			

List top 5 prescribing physicians ranked by volume of prescriptions for OX or HY, whichever is greater:

Name	DEA Registration	# Prescriptions Monthly	% to overall prescription volume

30. Does the pharmacy have a web site?

Yes ___ No ___ If yes, provide web address(es):

Note: If no, you are required to notify us immediately upon establishing a web site.

31. Will the pharmacy download and fill prescriptions on a per prescription fee basis from a website for dispensing?

Yes ___ No ___ If yes, provide web address(es):

32. Check the following types of payments the pharmacy receives for products and provide the approximate percentage of total payments:

Private Insurance	Yes ___	No ___	% of revenue
Medicare/Medicaid	Yes ___	No ___	% of revenue
Cash	Yes ___	No ___	% of revenue
Other	Yes ___	No ___	% of revenue

If other, provide details _____

33. Attach and date photographs of pharmacy building (2 of inside, including counter area & 2 of outside-front and back of pharmacy).

OTHER COMMENTS/OBSERVATIONS

I, as the Owner or [authorized representative or officer of the Owner], declare that I have completed this Retail Pharmacy Questionnaire and to the best of my knowledge and belief the information provided is true, correct and complete.

OWNER:
Name of Entity/Person
By: _____

Name:

Title:

Date:

I, as the authorized AmerisourceBergen representative, declare that I have reviewed this Retail Pharmacy Questionnaire with the owner or [authorized representative or officer of Owner] and to the best of my knowledge and belief the information provided is true, correct and complete. **I therefore recommend opening this account.**

AMERISOURCEBERGEN ASSOCIATE:
Signature _____

Full Name (Print)

Title

Cell Phone Number

Form will not be processed unless all questions are completed

Office Use Only

Name of BDM or Account Manager: _____

Phone of BMD or Account Manager: _____

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This questionnaire is to be completed by the Owner and Business Development Manager during an on-site visit

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 - e. Has this customer signed a Prime Vendor agreement? Yes ___ No ___
 - f. Does this customer have a PVA or equivalent with any other wholesaler?
Yes ___ No ___ If yes, name _____

2. Pharmacy Address: Travis County STAR Flight Quarters / UMCB

- a. Street: 601 E 15th. St.
- b. City Austin
- c. State TX
- d. Zip 78701

3. Pharmacy Phone Number: _____ Fax Number: _____

4. Pharmacy Email Address: _____

5. Check one:

- Start-up business. Other suppliers _____
- Existing business adding or changing suppliers. _____
Estimated monthly dollar volume _____
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Yes ___ No ___ If Yes, give details (when, why, etc.)

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13. Owner Phone Number: _____ Fax Number: _____

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15. Number of years owner has operated pharmacy _____

16. Is the Owner a licensed pharmacist?
Yes ___ No ___

17. Pharmacy DEA registration #: MT2203088

18. State BOP license # _____

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_____ (refer to: <http://www.deadiversion.usdoj.gov/meth/index.html#sales>)

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c. Verification process _____

d. Does the pharmacy use the State Rx monitoring program? ___ Yes ___ No ___ N/A

e. Does the pharmacy verify the physician's state license and/or DEA registration? ___ Yes ___ No

f. Does the pharmacy engage in discussions with prescribing physicians? ___ Yes ___ No If yes, how documented? _____

g. What is the pharmacy's procedure for reporting fraudulent Rx's?

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33. Attach and date photographs of pharmacy building (2 of inside, including counter area & 2 of outside-front and back of pharmacy).

OTHER COMMENTS/OBSERVATIONS

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OWNER:

Name of Entity/Person

By: _____

Name:

Title:

Date:

I, as the authorized AmerisourceBergen representative, declare that I have reviewed this Retail Pharmacy Questionnaire with the owner or [authorized representative or officer of Owner] and to the best of my knowledge and belief the information provided is true, correct and complete. **I therefore recommend opening this account.**

AMERISOURCEBERGEN ASSOCIATE:

Signature _____

Full Name (Print)

Title

Cell Phone Number

AmerisourceBergen Declaration of Eligibility for Contract Pricing

This document is a declaration of customer eligibility for contract pricing and similar items. This document will supersede all other signed documents pertaining to AmerisourceBergen's recognition of your Group Purchasing Organization affiliation or of any other bases establishing eligibility for contract pricing.

Contract pricing discrepancies regarding eligibility on group or individual contracts will be your responsibility to resolve. In the event a manufacturer disputes contract pricing, you will be credited with the amount paid and re-billed by AmerisourceBergen at the non-contract price in effect at the time the product was shipped to you.

If you have multiple affiliations, this document designates the Primary or Preferred Group Purchasing Organization. Multiple Primary affiliations will result in no incentives, tiers or fees being recognized.

This document must be signed within 30 days of its receipt by you or the initial start of service, whichever is earlier, in order to maintain Primary Group Purchasing contracts. Sales at contract pricing on an account will not be permitted without a signed declaration document.

Unless otherwise permitted by law, signature of this declaration constitutes a representation by you and your company that product received at contract pricing will be used only for its own use as defined in

Abbott Laboratories v. Portland Retail Druggist Ass'n, 425 U.S. 1 (1976) and that if you are also operating as a retail pharmacy you will maintain a separate inventory for your retail business. Any other use of these products will constitute cause for immediate termination of this account.

Please list the name, address, DEA and HIN number of the facility. List the Primary Group Purchasing Organization along with any secondary Group Purchasing Organizations if applicable. If there is more than one facility, please list all facilities on an attachment.

Bill To (Legal Entity)

Facility Name: Travis County
 Address: P.O. Box 1748
 City, State: Austin, Texas
 Zip: 78767-3101
 Telephone: _____
 Fax: _____

Ship To:

Facility Name: Starflight Crew Quarters DCMC
 Address: 4900 Mueller Blvd
 City, State: Austin, TX
 Zip: 78723-0000
 Telephone: _____
 Fax: _____

Other Names Under Which You Have Operated in the Last Year

Parent Corporation (if applicable)

D.E.A.# MT2632253

HIN# _____

Primary GPO Premier

AmerisourceBergen Division _____

Secondary GPO(s)

Bed Count (if applicable)

Your Name

Title

Signature

Date

AmerisourceBergen Corporation

Acct Mgr Signature

Date

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Bill To (Legal Entity)

Facility Name: Travis County
 Address: P.O. Box 1748
 City, State: Austin, Texas
 Zip: 78767-3101
 Telephone: _____
 Fax: _____

Ship To:

Facility Name: Starflight Quarters - UMCB
 Address: 601 E. 15th St.
 City, State: Austin, TX
 Zip: 78701-0000
 Telephone: 512-478-1311
 Fax: _____

Other Names Under Which You Have Operated in the Last Year

Parent Corporation (if applicable)

D.E.A.# MT2203088

HIN# _____

Primary GPO Premier

AmerisourceBergen Division _____

Secondary GPO(s)

Bed Count (if applicable)

Your Name

Title

Signature

Date

AmerisourceBergen Corporation

Acct Mgr Signature

Date