AmerisourceBergen
Besse Medical

Dear Valued Customer,

Besse Medical, and our parent company AmerisourceBergen, requires that all accounts who purchase opioid treatment medications complete and send back the attached form to document who at your shipping location is permitted to sign for opioid treatment medication orders. We strongly suggest you document all approved associates at your office with controlled substance signature authority. Please use the second form if you have more than three approved associates.

Please read CFR Requirement:

21 CFR 1301.74 (h) Requirement:

(h) The acceptance of delivery of narcotic substances by a narcotic treatment program shall be made only by a licensed practitioner employed at the facility or other authorized individuals designated in writing. At the time of delivery, the licensed practitioner or other authorized individual designated in writing (excluding persons currently or previously dependent on narcotic drugs), shall sign for the narcotics and place his specific title (if any) on any invoice. Copies of these signed invoices shall be kept by the distributor.

Please complete and submit this form via fax (888.736.8868) or email (accountsetup@besse.com). We will keep this form on file and will ask for periodic updates. Besse Medical will assume all information to be true and accurate unless notified by your practice. It is the responsibility of your practice to update Besse Medical with staff changes in regards to licensed practitioner and/or those with controlled substance signature authority. Failure to do so could result in termination of your account. Thank you in advance for your cooperation as we strive to distribute controlled substances with an emphasis on compliance.

Sincerely,
Besse Medical

AmerisourceBergen	Document Title			
	Narcotic Treatment Center Program Authorized Individual Signature Record			
	Document Number	**Version Number**	**Effective Date**	**Page**
	REG-FRM-027	1.02	12/16/2022	1 of 2
	Legacy Document: CSRA Form 27			
	Content Owner: Quality & Regulatory Assurance			

SIGNATURE RECORD

DEA NUMBER:
ACCOUNT NUMBER:
ACCOUNT NAME:
ADDRESS:
CITY:
STATE:
ZIP:
PHONE:

LICENSED PRACTITIONER (Print Name):
LICENSED PRACTITIONER (Signature): _____
TITLE: DATE:

OTHER AUTHORIZED INDIVIDUAL(S)

AUTHORIZED PERSON (Print):
AUTHORIZED PERSON (Signature): _____
TITLE: DATE:

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