CARDINAL HEALTH NEW ACCOUNT SETUP INFORMATION

Thank you for your interest in doing business with Cardinal Health! Completion of this new account packet will help ensure that we have all the necessary information to setup your new account quickly and accurately.

Instructions for completing packet:

****Items marked with a red * are required**

Page 1 – Shipping and Billing information

- Enter your shipping and billing information
    - Shipping addresses cannot be PO Boxes and must be verifiable via USPS.com
    - If you believe your shipping address to be valid and it cannot be verified on USPS.com we may ask you to obtain a letter from your local post office confirming the validity of the address.

Page 2 – MMCAP/340B

- Enter your MMCAP ID (We must have this information prior to setting up your account)
    - If you need to obtain a MMCAP ID please reach out to MMCAP Infuse at infuse-mn.gov to find the membership application
    - Completed application forms may be submitted to MMCAP Infuse for final processing, at mmcap_infuse.membership@state.mn.us. If you have any questions, please contact MMCAP Infuse at 651.201.2420.
- Advise us if you will be setting up a 340B account and what HRSA ID(s) will be used

Page 3 - Licensing

- Provide us with accurate license information under which you will make your pharmaceutical purchases
    - If utilizing a state pharmacy license the address on the license must match the shipping address provided on page 1 and a copy of the license must be provided
    - If utilizing a physician license a copy of the license must be provided and a completed and signed letter of authorization provided (template on page 9)
- Controlled Substance Purchases
    - A DEA certificate must be provided to purchase controlled substances
    - The DEA must show the same name and address as the information provided on page 1 and must match the state pharmacy license name and address as well
    - If you utilized a physician license and would like to add the physician's DEA the address on the physician's DEA must match the shipping address provided on page 1. A letter of authorization cannot be used to authorize the use of a DEA with a different shipping address.
- State control licenses
    - If your state requires a state controlled substance license a copy of that license should be provided.

Page 4 – Transportation and Inventory

- Provide your business hours, delivery hours and delivery days
- It is very helpful to have item usage information provided at the time of account setup.
    - If you are moving to Cardinal from another distributor please ask the previous distributor for a 6 month purchase history report in Excel format.
    - If you do not have the ability to obtain that information you can also compile usage information in Excel format from past supplier invoices or you may utilize our item usage form on Page 7 of this packet (You may need to complete that document multiple times if you have a lot of items to list)
- Please provide an anticipated or estimated monthly volume if possible.

Page 5 – Payment Information

- Please advise if you are exempt from Sales Tax and if you are please provide a tax exempt certificate (W9's do not indicate an exempt status)
- Please choose your payment terms. The default is 30 days from invoice however you may choose what is best for your facility or organization.
    - NOTE: If you are interested in any pre-pay options please consult with your Cardinal Regional Leader prior to submitting your new account packet.
- If you would like invoices emailed to any individual or AP email address please provide an appropriate email address. (You can have up to 4 email addresses receive copies)
    - NOTE: You will receive an invoice copy with each delivery and invoice copies are also available for printing or download from the Order Express online ordering system.

Page 6 – Order Express (Online Ordering) Access

- Please provide the full name, email address and telephone number for everyone who requires access to Order Express.
    - If any persons should have administrator rights please check the box next to the appropriate name (Administrators have the ability to add/delete users as well as other additional functions)
- There is an additional notes section for any comments or concerns

Page 7 – Item Usage form

- Refer to page 4 instructions
- You will not initially have an account number or DC so you may bypass those fields if using the form to supply your anticipated usage

Page 8 – PDMA (Returned Goods Authorization)

- This form must be completed and on file prior to being able to return product to Cardinal Health. The document is confirmation that you will store and handle the products properly so they may be resold upon return to Cardinal Health.

Page 9 – Letter of Authorization

- To be completed if utilizing a physician license for purchases (refer to page 3 instructions above)

Page 10 – Prison Restricted Form

- This form is required to access certain products that have been deemed by select manufacturers as ineligible for purchase by state prisons, penitentiaries, jails, or other incarceration facilities as well as any other customer deemed 'unqualified' by the manufacturers
- If you have no interest or need to purchase items restricted by some manufacturers you do not need to complete the form and thus will not have access to the items.
- If you have further questions regarding the completion of this form please speak with your Regional Leader or Account Management Representative

Ship to Information	
Ship to Name*	
Ship to Name 2	
Ship to address*	
Ship to address 2	
City*	
State*	
Zip*	
Telephone*	
Extension	
Fax	
Contact Name*	
Contact Email*	
Bill to Information	
Same as Ship to	☐
Bill to Name	
Bill to Name 2	
Bill to Address	
Bill to Address 2	
Bill to City	
Bill to State	
Bill to Zip	
Bill to Telephone	
Extension	
Bill to Fax	
Bill to Contact Name	
Bill to Contact Email	

MMCAP INFO (A MMCAP ID is required to begin account setup)	
MMCAP ID*	
HIN (Health Industry Number) *Leave blank if not known	

340B INFORMATION If you would like a 340B account setup please complete the below information. We must setup a separate account for each HRSA ID provided. If you do not need a 340B account you may leave this section blank.	
Are you 340B eligible?	
340B ID(s)	

STATE LICENSE INFORMATION **In order to purchase Rx products you must provide either a State Pharmacy License (The name and address on the State Pharmacy License must match the Shipping Name and Address provided) or a Physician License with a completed and signed Letter of Authorization (see template page 9). COPIES OF LICENSES ARE REQUIRED**		
If Physician License Physician Name (Enter Physician Name and License information) **Complete and return signed Letter of Authorization with License Copy**	Physician Name	
	License number	Expiration
If State Pharmacy License Provide license number and expiration and **provide a copy of license**	License number	Expiration
DEA LICENSE INFORMATION **Will you be purchasing controlled substances? If so, please provide your DEA certificate and expiration as well as a copy of the license.**		
Will you be purchasing controlled substances?		
Provide license number and expiration and **provide a copy of license**	License number	Expiration

DELIVERY INFORMATION Please enter your Business hours and Delivery hours as well as which days you wish to receive deliveries					
Business Hours (whole hours)*			TO		
Delivery Hours (whole hours)*			TO		
Delivery Days (check each day you would like to receive delivery)* *MMCAP allows up to 5 days of free delivery	M ☐	T ☐	W ☐	R ☐	F ☐

USAGE INFORMATION If you are moving to Cardinal from another distributor please have the previous distributor provide a 6 month purchase history report You may also utilize the usage form template on page 7	
Anticipated/Estimated Monthly Volume ($$)	

TAX INFORMATION					
Are you exempt from Sales Tax?					
If yes, please provide a copy of your tax exempt certificate					
INVOICE TERMS					
Please choose your invoice terms* 30 Day Net is the default unless you choose otherwise	30 Day Pre-Pay	○		15 Day Net	○
	15 Day Pre-Pay	○		30 Day Net	◉
	7 Day Pre-Pay	○		45 Day Net	○
	Next Day Pay	○		60 Day Net	○
	7 Day Net	○		90 Day Net	○
Do you want invoices emailed to you? You will receive a paper invoice with each delivery. If yes you may enter up to 4 email addresses.					
Email 1					
Email 2					
Email 3					
Email 4					

ORDER EXPRESS (ONLINE ORDERING) ACCESS			
NAME	EMAIL	PHONE	ADMIN
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

ADDITIONAL NOTES OR COMMENTS

Item usage add / change form

Account name: _____ Account number: _____ DC: Lavergne

To continue to provide you with the best possible inventory service levels, please utilize this form to make updates to your product usage. Usage addition requests could take up to 2–4 weeks before the product is available in your distribution center. Please note, usage addition requests should be submitted if you plan to purchase the item within the next 4–6 weeks. If your product is needed after 4–6 weeks, please indicate when you need the product in the effective date column.

Demand Shift

Old CIN	New CIN	New Item Description	Incremental Monthly Usage	Total Monthly Usage	Effective Date (Start for new usage)

New CINs

New CIN	Description	Incremental Monthly Usage	Total Monthly Usage	Effective Date (Start for new usage)

Print name: _____ Phone #: _____ Date: _____

Please send completed forms to:

Radcliff Customer Service Center (servicing Eastern Time Zone DC Customers)

- **E-mail** by clicking **Submit - Radcliff Customer Service** or your regular Customer Service e-mail
- **Fax** - 1-877-372-3998 or your regular Customer Service Fax #

Sherwood/Little Rock Customer Service Center (servicing Central, Mountain, and Pacific Time Zone DC Customers)

- **E-mail** by clicking **Submit - Sherwood Little Rock Customer Service** or your regular Customer Service e-mail
- **Fax** - 1-877-309-3076 or your regular Customer Service Fax #
- **Hospital/Multispecialty** – 855.855.0708
- **Physician Office** – 877.453.3972

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CARDINAL HEALTH RETURNED GOODS AUTHORIZATION ONGOING ASSURANCE

The undersigned customer ("**Customer**") of Cardinal Health, (the "**Wholesaler**") hereby agrees that this document is being delivered to confirm Customer's compliance with applicable federal, state, and local laws / guidelines concerning returned goods and shall apply to all returns by Customer to Wholesaler from time to time and shall supersede any inconsistent provisions which may be contained in any credit request, purchase order, or other documents pertaining to the supply relationship between Customer and Wholesaler.

Customer represents, warrants, and guarantees to Wholesaler that: (a) each such return shall be made only to the specific Wholesaler from which the item was originally purchased; (b) each such return shall be accompanied by Wholesaler's credit request form (the "**Return Form**"), which shall specify both Customer's and Wholesaler's name and address, the date of the return, the quantity and description of the product returned, and such other information as may reasonably be requested on Wholesaler's Return Form; (c) Customer shall retain a copy of each Return Form and related credit memo and make such documentation available to the manufacturer and to authorized federal, state, and local law enforcement officers upon request; (d) the credit claimed or accepted by Customer for any such return shall not exceed the original purchase price paid to Wholesaler; and (e) all merchandise returned to Wholesaler has been stored and handled by Customer in accordance with all applicable federal, state, and local laws, manufacturer guidelines when disclosed to customer by the manufacturer or wholesaler, and good trade practices, and such merchandise has not been adulterated or misbranded by customer within the meaning of the Federal Food, Drug, and Cosmetic Act and meets all FDA, state, and other applicable requirements and guidelines.

_____
Print Customer Name (i.e., Store Name) (Include all that apply)

_____

_____

_____
Print Store Address

_____
By Authorized Person / Title (Print)

_____ _____
Date Signature of Authorized Person

Date:

Cardinal Health
7000 Cardinal Place
Dublin, OH 43017

I, Physician Name , am the responsible person for purchases made by Facility Name and Address under my state license number Physician State License Number issued by the State of .

I will notify Cardinal Health immediately if my responsibility status and/or relationship with this facility is changed or terminated.

Physician Signature: _____

Attachments: copy of physician, physician assistant or nurse practitioner state license

Request for Approval to Access Prison Restricted Products

We understand that you are interested in purchasing items that you are currently restricted from ordering. In order to better understand your business and provide a decision as to your eligibility to purchase the items from which you are restricted please read and respond to the following questions, sign and date, and return this form to Cardinal Health.

1) Are you in business as a correctional facility? (e.g. prison, local or county jail, re-entry center, juvenile detention, or any other correctional affiliation)

   Yes ☐ No ☐

2) Does your facility provide products by either purchasing for or distributing to a correctional facility, either directly or indirectly, as outlined above?

   Yes ☐ No ☐

Customer hereby certifies that the questions above have been responded to accurately and truthfully. Customer agrees to notify Cardinal Health immediately should their business model change as to become a correctional facility or engage in any future business activities with a correctional facility (e.g. prison, local or county jail, re-entry center, juvenile detention, or any other correctional affiliation).

Customer Account Name_____

Distribution Center Select DC..._____

Customer Account #

or DEA# _____

Signature_____

Title_____

Date_____