

Schedule III – V Inventory Form Instructions

PLEASE READ INSTRUCTIONS CAREFULLY. THEN COMPLETE THE "SCHEDULE III – V INVENTORY FORM" IN FULL AND INCLUDE ALONG WITH SCHEDULE III – V DRUGS TO:

EXP Pharmaceutical Services Corp.

48021 Warm Springs Boulevard
Fremont, CA 94539

1. Enter **DEA Name, DBA (Doing-Business-As)** and **complete address** (as indicated on your DEA Controlled Substances Registration Certificate) along with your **Wholesaler Information**.
2. Enter **EXP Account Number**, if you do not have an EXP Pharmaceutical Services Account Number insert the word **"NEW."**
3. **Buying Group** is the name of your GPO or GSO (e.g. PREMIER).
4. Enter **Shipper Phone Number, DEA Number** and **DEA Expiration Date**.
5. When listing Schedule III-V Controlled Substances: *(See example below)*
 - a. List the Schedule III-V Controlled Substances that will be sent.
 - b. Partials **must** be listed on a separate line.
6. Completed form must be signed and dated by authorized registrant.
7. Make a copy for your files and send the original copy along with your shipment to EXP Pharmaceutical Services Corp.

COLUMNS ARE PROVIDED FOR QUANTITIES AND ITEM IDENTIFICATION. THE FIRST COLUMN HAS 2 SECTIONS FOR FULL CONTAINERS. SECTIONS ARE FOR QUANTITY AND ORIGINAL PACKAGE SIZE (i.e. 2 BOTTLES OF 2 ML x 10, ETC). THE NEXT COLUMN HAS 3 SECTIONS FOR PARTIAL CONTAINERS. SECTIONS ARE FOR QUANTITY, PARTIAL COUNT, AND ORIGINAL PACKAGE SIZE (i.e. 1 BOTTLE WITH 4 PARTS OF 10). THE LAST 2 COLUMNS ARE FOR IDENTIFICATION AND REQUIRE YOU LIST THE ITEM NAME, FORM, STRENGTH AND NATIONAL DRUG CODE.

EXAMPLE

ITEM NO	FULL PKG		PARTIAL PKG			COMPLETE IN FULL AND PLEASE PRINT CLEARLY	
	QTY	PKG SIZE	QTY	PARTIAL COUNT	PKG SIZE	ITEM NAME (Description including Name, Form and Strength)	NATIONAL DRUG CODE
1.	2	10				VERSED VIAL 2ML 1MG/ML	00004-1998-06
2			1	4	10	VERSED VIAL 2ML 1MG/ML	00004-1998-06
3			2	5	10	VERSED VIAL 2ML 1MG/ML	00004-1998-06
4							
5							

PLEASE READ INSTRUCTIONS ON THE FORM CAREFULLY AND COMPLETE IN FULL.
PLEASE PRINT CLEARLY.
IF FURTHER CLARIFICATION IS NEEDED, PLEASE CALL (800) 350-0397.

SHIPPER INFORMATION:				WHOLESALE INFORMATION:			
DEA NAME:				NAME:			
DBA NAME:							
ADDRESS:				ADDRESS:			
ADDRESS:				ADDRESS:			
CITY:	STATE:	ZIP:		CITY:	STATE:	ZIP:	
EXP ACCT#:	BUYING GROUP:			WHSL ACCT#:			

Shipper Phone No.: () - DEA No.: DEA Exp. Date _____

Print Name (Authorized Registrant) _____ Signature (Authorized Registrant) _____ Date _____

NOTE: EXP Pharmaceutical Services RECOMMENDS USING A SHIPPING METHOD THAT CAN TRACK AND CONFIRM DELIVERY OF YOUR SHIPMENT.

ITEM NO	FULL PKG		PARTIAL PKG		COMPLETE IN FULL AND PLEASE PRINT CLEARLY		
	QTY	PKG SIZE	QTY	PARTIAL COUNT	PKG SIZE	ITEM NAME (Description including Name, Form and Strength)	NATIONAL DRUG CODE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							