CMPS Policy on Benzodiazepines and other Controlled Substances

According to the 2012 National Survey on Drug Use and Health, almost twice as many Americans (6.8 million) currently abuse controlled pharmaceuticals than those using cocaine, heroin, hallucinogens, and inhalants combined. As prescribers, we are ethically and legally obligated to take precautions to ensure that controlled substances we prescribe are not being misused or diverted.

In addition to this obligation, our first obligation is to your health and well-being. Benzodiazepines (such as Ativan/lorazepam, Valium/diazepam, and Klonopin/clonazepam) are potentially lethal in overdose, especially when used in combination with alcohol or opioids. Side effects and risks of benzodiazepines include, but are not limited to: memory and thinking problems; dementia; worsening anxiety, PTSD, COPD or sleep apnea; physical dependence and withdrawal symptoms; overdose; arrest for driving while impaired; increased risk for falls, broken bones and concussion. These medications were developed for short-term use in extreme situations. The likelihood of experiencing adverse effects, and decreased efficacy of the medication, is more likely with regular or long-term use. <u>While each patient will be evaluated on a case-by-case basis, if you are prescribed benzodiazepines at CMPS it will be your provider's goal to decrease and discontinue their use as much as possible over time.</u>

With these concerns in mind, we have written the following agreement in the interest of promoting optimal drug therapy while minimizing risks to the patient and the health provider:

1. I, _____ agree not to increase the dose or frequency of my medication without first discussing it with my psychiatric provider. I understand that expected prescription refill dates will be used to promote optimal use of this medication.
2. If prescribed controlled substances, my provider will require baseline and random laboratory drug screening or pill counts as a matter of routine monitoring.
    a. Screening and pill counts may occur while I am in the office during appointments, or I may be potentially notified of the need for screening or pill counts in between appointments and given a 24-hour window to present myself at the CMPS office for monitoring.
    b. <u>All results are final and any inconsistencies may result in discontinuation of controlled substances, and/or discharge from the practice.</u>
3. I will attend all scheduled appointments, treatments, and consultations as requested by my provider. I understand that I should check with my provider or pharmacist before taking over-the-counter medications and/or herbal supplements.
4. I agree to be responsible for the secure storage of my medication at all times. I understand the importance of not informing others about my controlled substance therapy. I agree not to give or sell my prescribed medication to any other person.
5. I agree to attend and meaningfully participate in psychotherapy if my provider makes it a condition of being prescribed benzodiazepines.
6. I understand the following refill policy will apply, unless I have made previous arrangements with my provider:
    a. **Early medication authorizations will not be granted, even if they have been lost, stolen, or destroyed.**
    b. **Medication authorizations will not be given on Fridays, weekends, or holidays.**
    c. **Medications will not be refilled by other physicians or providers.**
7. I have been fully informed of the potential psychological and physiological dependence risks of controlled substances; I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect. I know that I may become physically dependent on the medication. This will occur if I am on the medication for several weeks; when I stop the medication, I must do so slowly and under medical supervision, or I may have withdrawal symptoms.
8. I consent to open communication between my provider and any other health care professionals involved in my medication management, such as pharmacists, other providers, emergency departments, etc.
9. **I understand that if I break this agreement, our healthcare provider - client relationship will be terminated.**

Signature of Patient/Guardian: _____ Date: _____