RRHC Agreement for Treatment with Controlled Substances

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. The following conditions must be followed by doctor and patient to prevent abuse or diversion.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception.
2. All controlled substances must be obtained at the same pharmacy. This agreement may be issued to the pharmacy. The pharmacy that I have selected in ________________ in ________________.
   Phone:______________________________.
3. The prescribing physician has permission to discuss treatment details with my pharmacy and any law enforcement agency in the investigation of any misuse, sale, or other diversion of my pain medication.
4. I will not share, sell or otherwise permit others to have access to these medications.
5. My Provider may request urine or serum drug screens without notifying me in advance, and I agree to cooperate with this testing. If I am on the sliding scale for payment, I will be required to pay LabCorp for this testing. Presence of unauthorized substances (legal or illegal) will result in discontinuation of medications and discharge from the practice.
6. Medications should be closely safeguarded. They should not be left where others might see or otherwise have access to them.
7. Medications will not be replaced if they are lost, stolen, destroyed, etc.
8. Early refills will not be given
9. For any renewals, I must keep my scheduled appointments. I will not phone for prescriptions after hours or on weekends. Refills for narcotics will not be phoned in to the pharmacy (unless previously discussed with Provider and documented in the chart).
10. I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at greater rate will result in my being without medication for a period of time.
11. I will be respectful and courteous to primary care staff at all times. If I do not follow this rule, it will result in my discharge from the practice.
12. I will not use my medication in ways or routes other than prescribed.
13. I understand that there may be consultation with other medical providers including specialists to discuss my case.
14. The provider retains the right to discontinue controlled substances at his/her discretion based on suspected misuse or abuse at anytime.
15. I have received the controlled substance information which includes information about withdrawal from controlled medications.

Patient Signature: ____ Date:________________

Physician Signature:____ Date: ________________

RITCHIE REGIONAL HEALTH CENTER
POLICY & PROCEDURES MANUAL

CHRONIC NARCOTIC AND OTHER CONTROLLED SUBSTANCES POLICY

I. **Controlled substances are defined as any substance governed under the Controlled Substance Act.**

II. **Chronic controlled substance therapy will be defined as treatment for over 90-days.**

a. Chronic pain treatment due to cancer is exempt from this policy.

b. New patients who present should be informed that we may not start or continue chronic opiates, or any other controlled substance such as benzodiazepines, even if they have been prescribed previously. They may be referred to pain management or another appropriate specialist.

c. If an existing patient transfers from another RRHC provider and has been prescribed a chronic controlled substance, the new medical provider can determine whether or not continuing the medication is appropriate.

d. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.

e. Opioids should not be prescribed when possible harms outweigh potential benefits.

III. **Patients who continue to receive a chronic opiate should have regular monitoring of appropriate use.**

a. All patients on controlled substances must sign the Controlled Substance Contract. This form must be updated and reviewed with the patient at least annually. A copy will be provided to the patient and a copy scanned in the EMR.

b. Patients should be seen on a regular basis – at least every 3 months and perhaps monthly. Appointments should be scheduled with a single provider.

c. If prescriptions are lost or stolen they are not replaced; per the Controlled Substance Contract. Lost or stolen medications may cause discontinuation of prescriptions for opioid medications. Clinicians should utilize e-prescribing to mitigate the risk of diversion.

d. Any written prescriptions picked-up on location will require the patient or proxy to provide identification and a signature as verification. Designated staff involved in this process will be required to initial to signify that proper identification was provided.

e. Clinicians will review the patient's Board of Pharmacy report at each visit.

f. Clinicians should use urine drug testing at least annually to assess prescribed medications – as well as other controlled prescriptions drugs and illicit drugs. More frequent testing and testing for specific synthetic or illicit drugs should be done if warranted. (1) All information should be entered in the EMR.

g. It is strongly encouraged that all prescriptions for controlled drugs should be prescribed through the electronic medical record. On rare occasions where EMR is not available, any hand-written prescriptions should have the medication, dose, number of pills, dates prescribed, and other appropriate information also entered into the electronic medical record at a later time. If prescriptions are hand-written, they must be scanned in to EMR along with the electronic prescription noted "documentation only".

h. An annual visit with a behavioral health specialist should be considered for all patients prescribed chronic opiates.

IV. Existing patient on chronic opiate therapy should be treated with the lowest effective dose.

a. Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.

b. Caution should be used when prescribing extended-release/long acting opioids. ER/LA opioids should be reserved for severe, continuous pain. In general, avoiding the use of immediate-release opioids in combination with ER/LA opioids is preferable, given the potentially increase risk and diminishing returns with such an approach to chronic pain.

c. When opioids are reduced or discontinued, a taper slow enough to minimize symptoms and signs of opioid withdrawal should be used. A decrease of 10% of the original dose per week is a reasonable starting point; experts agree that tapering plans may be individualized based on patient goals and concerns. Experts note that tapers slower than 10% per week (e.g. 10% per month) also might be appropriate and better tolerated than more rapid tapers particularly when patients have been taking opioids for longer durations.

V. Clinicians should evaluate the benefits and harms of continued therapy with patients every 3-months, or more frequently. Opioids should not be prescribed where possible harms outweigh potential benefits.

a. RRHC patients should not be prescribed a chronic benzodiazepine with an opiate. If a patient is prescribed both, then the provider will consult with the patient to determine what medication should be discontinued.

b. RRHC patients with the following disorders should be strongly encouraged to not be prescribed a chronic opiate: 1) history of diversion, misuse or substance use disorder; 2) history of drug overdose; 3) alcohol misuse; 4) fibromyalgia; 5) headache; 6) severe depression.

c. Certain risk factors are likely to increase susceptibility to opioid-associated harms and warrant incorporation of additional strategies into the management plan to mitigate risk. These include: 1) sleep-disordered breathing including sleep apnea, congestive heart failure, and obesity; 2) pregnant women; 3) patients with renal or hepatic insufficiency; 4) patients aged over 65 years; 5) patients with mental health conditions, 6) patients on higher opioid dosages.

d. Clinicians should incorporate into the management plan strategies to mitigate risk, seeing patients more frequently, referring to pain and/or behavioral health specialists when factors that increase risk for harm are present.

VI. Dysfunctional Use of Controlled Substances (DUCS)

a. A finding of dysfunctional use of controlled substances (DUCS) renders the patient ineligible for prescriptions for the medications in question. A finding of DUCS is made if one or more of the following events occur during chronic pain management treatment:
   i. Evidence of diversion
   ii. Evidence of obtaining opiate mediation from multiple sources without clear medical indication
   iii. Altering prescriptions or records
   iv. Unlabeled hazardous use of controlled mediation
   v. Use of illegal substances
   vi. Use of controlled substances not prescribed by provider
   vii. Pill counts that are not consistent with prescribed medications
   viii. Non-compliance with treatment plan, including failure to take medication as prescribed, failure to obtain urine testing, or missing regular appointments for pain monitoring.
   ix. Threatening or aggressive behavior with staff members regarding their pain medication
b. Recording and Process for Dysfunctional Use of Controlled Substances
   i. The provider should clearly document the evidence for dysfunctional use in the EMR.
   ii. This information should be sent to the supervising/collaborating physician. Physicians will review all information, provider input, and documentation with the Medical Director and they will collaboratively decide to:
      1. Discontinue controlled medications based on evidence, but continue primary care services.
      2. Discontinue all services to the patient in cases where warranted, for example threatening or aggressive behavior or altering prescriptions or records.
   iii. If discontinuation of all services is decided, the recommendation is then forwarded to a member of the senior management staff, who notifies the patient in writing of the determination.
c. DUCS designation is clearly indicated in the EMR under the yellow "sticky-tab" function of the EMR.

d. Once the patient has been designated with DUCS, the patient will no longer be prescribed any controlled medication by any RRHC provider at any site.
e. If evidence of addiction, clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment) for patients with opioid use disorder or other addictions.

Includes key elements from "CDC Guideline for Prescribing Opioids of Chronic Pain - United States 2016" published in MMWR, Volume 65. March 15, 2016 (1).

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14. The provider retains the right to discontinue controlled substances at his/her discretion based on suspected misuse or abuse at anytime.
15. I have received the controlled substance information which includes information about withdrawal from controlled medications.

Patient Signature: ______________________________ Date: ____________

Physician Signature: ______________________________ Date: ____________

RRHC Controlled Substance Procedure

- Patients taking chronic controlled substances will have a controlled substance contract in chart.
    - Completed at first visit if patient is already taking a controlled substance.
    - Patient will sign a contract as soon as controlled substance is prescribed.
- Urine drug screen will be at the discretion of the provider, but no less than yearly; ex. 3-months, 6-months, yearly, and/or random.
- The urine drug screen may be obtained at next scheduled appointment or patient may be called at random date/time at provider discretion.
- Interpretation and action in regard to urine drug screening will be at the discretion of the provider. Next steps are outlined in the Dysfunctional Use of Controlled Substances (DUCS) section of the policy.
- Board of Pharmacy report must be checked and noted in the chart prior to next patient visit with provider and prior to any prescriptions faxed, called-in, or written scripts given.
- Any written prescription picked-up on location will require:
    - The patient or proxy to provide a driver's license.
    - The patient or proxy to sign to verify receipt of prescription.
- All documents will be scanned in to the patient's chart (i.e. copies of written prescription, driver's license, signature of receipt). Documents will be consistent in label and scanned placement in medical records.

Opioid Morphine Equivalent Conversions Common Outpatient Drugs

(Centers Disease Control and Prevention Atlanta, GA, May 2014)

DEA Schedule	Generic Name of Narcotic	Common Trade Name	MME Conversion	MME 50 mg/day
II	Buprenorphine Film	Suboxone* ,Subutex	10	5
II	Fentanyl Patch	Duragesic	7.2	7
II	Oxymorphone	Opana	3	17
II	Oxycodone	Oxycontin, Percocet, Roxicodone	1.5	33
II	Hydrocodone	Narco, Lortab, Vicodin	1	50
II	Morphine	MS contin, Roxanol	1	50
II	Tapentadol	Nucynta	0.4	125
III	Codeine	Tyelenol #3, Fiorinal, Empirin	0.15	333
IV	Tramadol	Ultram	0.1	500

* Suboxone is buprenorphine/naloxone in fixed dose

Common Prescription Controlled Substances - DEA Controlled Substances List Jan 11, 2016

DEA Schedule	Generic Name	Common Trade Names Name	DEA Number	Narcotic Y/N
II	Amphetamine	Adderall	1100	N
II	Buprenorphine	Suboxone,Subutex	9064	Y
II	Fentanyl	Duragesic	9801	Y
II	Hydrocodone	Narco, Lortab,Vicodin	9806	Y
II	Methylphenidate	Conterta, Ritalin	1724	N
II	Morphine	MS contin, Roxanol	9300	Y
II	Oxycodone	Oxycontin, Percocet, Roxicodone	9143	Y
II	Oxymorphone	Opana, Numorphan	9652	Y
III	17-Alpha-methyl-testerostone	Testerostone	4000	N
III	Butalbital	Fiorinal	2100	N
III	Codeine preparations	Tyelenol #3, Fiorinal, Empirin	9804	Y
III	Testerostone	Testerostone, Striant	4000	N
III	Testosterone cypionate	Depo-testosterone	4000	N
III	Testerostone topical	AndroGel	4000	N
IV	Alprazolam	Xanax	2882	N
IV	Clonazepam	Klonopin, Clonopin	2737	N
IV	Diazepam	Valium	2765	N
IV	Phentermine	Adipex, Fastin, Qsymia	1640	N
IV	Sibutramine	Meridia	1675	N
IV	Temazepam	Restoril	2925	N
IV	Tramadol	Ultram	9752	Y
IV	Zaleplon	Sonata	2781	N