Benzodiazepine Medication Agreement

This document is an agreement between patient and physician regarding the use of benzodiazepines, a class of controlled substance medications used to treat a variety of conditions including anxiety, insomnia, muscle spasticity, convulsive disorders, as well as detoxification from alcohol and other substances. This document establishes clear guidelines for the safe use of these medications. This agreement is intended for patients with an established or anticipated chronic use of a benzodiazepine medication, defined as 90 or more days of use in a 12-month period.

I: _____ DOB: _____, agree to use the medication: _____ prescribed by: _____ for the diagnosis of: _____.

I am aware that use of benzodiazepines has certain associated risks, including but not limited to:

- Drowsiness, fatigue, grogginess
- Dizziness
- Blurred vision
- Headache
- Poor concentration, confusion
- Impaired coordination
- Memory loss
- Stomach upset
- Depression
- Subtle personality changes
- Dreaming/nightmares
- Muscle weakness
- Abuse/death
- Psychological addiction

I agree to and understand the following:

1. I understand that the purpose of this medication is to treat the diagnosis listed above and ultimately improve my quality of life. Alternative therapies were explained and offered, including the possible risks and benefits of other types of treatments that do not involve the use of benzodiazepines.

2. I will not be involved in any activity that may be dangerous to me or someone else while taking this medication. I am aware that benzodiazepine use slows reflexes and reaction time, increasing the risk of motor vehicle accidents. Activities that could be dangerous include, but are not limited to, operating heavy equipment or motor vehicles, working in dangerous environments, or being responsible for another individual who is unable to care for himself or herself.

3. I am aware that tolerance can occur with the use of benzodiazepines. Tolerance is defined as a need for a higher dose to maintain the same effect. If my prescribing physician determines that continued escalation of the dose is not in my best interest, then the benzodiazepine may need to be tapered and discontinued and may necessitate another form of treatment.

4. I understand that physical dependence is possible within a few weeks of starting benzodiazepine therapy. I am aware that physical dependence means that if my benzodiazepine use is markedly decreased, stopped, or reversed, I could experience a withdrawal syndrome, including but not limited to, sweating, increased heart rate, insomnia, abdominal cramps, tremors, diarrhea, muscle or bone aching, and seizures, which may occur within 24 to 48 hours of last benzodiazepine dose. Benzodiazepine withdrawal may require hospitalization, and in rare cases, can be life threatening. If I want to decrease my dose or stop taking the medication, I will consult with my physician first.

5. I understand that psychological addiction is a possible risk to the use of benzodiazepines. Addictive behavior is reason for the drug to be tapered and discontinued. Examples of addictive behavior include, but are not limited to:

    a. Taking a drug to obtain euphoria

    b. Demonstrating drug-craving or drug-seeking behaviors, such as visiting multiple doctors and/or pharmacies in pursuit of medications

    c. Taking more medication than prescribed without correlation to symptom relief

    d. Exhibiting a manipulative attitude toward a provider to obtain a drug

6. **Females only**: I understand that while on benzodiazepine therapy I should maintain safe and effective birth control. If I plan to become pregnant or believe that I am pregnant while taking this medication, I will immediately notify my provider. I am aware that benzodiazepines cross the placenta, can cause birth defects, and are generally avoided during pregnancy. They may lead to the development of dependence and consequent withdrawal symptoms in the fetus. Benzodiazepines are excreted in breast milk and are usually contraindicated in breastfeeding mothers.

7. **Patients aged 65 years and older**: I understand I am at a higher risk of side effects, including, but not limited to falls and problems with thinking and memory, due to slower drug metabolism that naturally occurs with aging.

8. All controlled substances must come from the provider whose signature appears below or, in his or her absence, by the covering provider, unless specific authorization is obtained for an exception. I will tell my provider about all other medications and treatments I am receiving.

9. Since these medications have the potential for misuse and abuse, strict accountability is necessary when use is prolonged. I understand the importance of compliance to the rules outlined in this agreement to protect my access to controlled substances and to protect my provider's ability to prescribe to me.

10. I will take medication as prescribed by my provider. I will communicate fully with my provider about the character and intensity of my symptoms, the effect on my daily life, and how well the medicine is helping to relieve them.

11. I will not increase or change how I take my medications without consultation with my provider during scheduled appointments (not via phone, at night, on weekends or holidays). This includes abrupt discontinuation of the benzodiazepine medication.

12. I will not ask for refills earlier than the prescribed interval. Lost or misplaced prescriptions will not be replaced.

13. I will keep my medications and prescriptions in a secure, safe place, preventing others' access to these medications.

14. If my medication is stolen, a copy of the police report must be given to my provider for a replacement to be considered.

15. Timely requests (at least three business days) for refills are my responsibility. Refill requests of my prescriptions for benzodiazepines will be made only at the time of an office visit, by phone, or via the patient portal. Refill requests won't be processed on nights, weekends, or holidays.

16. In accordance with state law, prescriptions must be ordered by my provider electronically (e-prescribed) and will not be mailed.

17. My provider may send a prescription to my pharmacy before the day the refill is due, but the prescription cannot be filled until the 'do not fill until' date on the Rx, which is determined by the provider, last refill date, Maine state law, and/or pharmacist.

18. I will not place calls to the office staff with demands for variations or exceptions to the contract.

19. I will not be disrespectful, use profanity, or harass the office staff, and I understand that doing so could be grounds for discharge from InterMed.

20. I will not share my medication with anyone.

21. Renewals are contingent upon me keeping scheduled appointments and following prescription directions.

22. I understand that my prescribing provider will review my benzodiazepine prescription with me annually, or sooner if indicated by my provider, during an office visit.

23. I understand that my provider will verify that I am receiving only the controlled substances I reported previously and only from prescribers that have been previously reported by checking the Maine Prescription Monitoring Program website, as required by law.

24. I understand that I can only fill prescriptions at a pharmacy located in Maine unless an out-of-state pharmacy is agreed to by the prescribing physician.

25. I will not request benzodiazepines or controlled substances from other providers, including any Emergency Room (ER) without also notifying my prescribing provider at InterMed. I understand that other providers should not change the dose of my benzodiazepine, and I will notify my provider of any changes to my medications made by another provider and the reason for the change.

26. I will inform my other healthcare providers, including ER providers, that I am taking these benzodiazepines and that I have signed a benzodiazepine contract with the physician listed below.

27. I will inform my provider of all other medications and substances I am taking, to include over the counter, herbal, and prescribed medications, as well as past and present use/misuse of alcohol and substances (illicit, recreational, street drugs).

28. I was advised by my provider that alcohol and substance use are not recommended with this medication, and their use can cause serious side effects, including life-threatening reactions, when used alone and/or in combination with this medication.

29. I am aware that if I am found to be using illegal substances (e.g., cocaine) my provider may stop prescribing this medication.

30. I will inform my provider of any new medications or medical conditions, including ER treatment or pregnancy.

31. I will participate in any medical, psychological, or psychiatric assessments or treatment programs designed to improve the safety and benefit of the benzodiazepine treatment plan as recommended by my provider.

Patient Initials _____

32. I will not use another person's prescriptions.

33. My use of this medication will be limited to times when I am not driving or operating machinery and shall be used in a manner consistent with my provider's recommendations.

34. I understand I should not take Z-drugs [zolpidem (Ambien™), eszopiclone (Lunesta™), zaleplon (Sonata™)] while on this benzodiazepine medication. Doing so can put me at risk of death due to the combined effects on breathing. I agree to notify my doctor if new medications are added to my regimen.

35. I consent to random drug screenings, to ensure I am only taking prescribed drugs. I understand that all out-of-pocket expenses associated with drug screenings will be my responsibility.

36. I consent to random inventory checks (pill counts). If requested, I will bring my medication, in the original container, to InterMed at a requested time, so that the clinical staff may verify the amount of medication I have.

37. I agree to waive any applicable privilege or right to privacy or confidentiality with respect to the prescribing of my medications and authorize my providers, pharmacy, and insurers to cooperate fully with any city, state, or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion or inappropriate use of my benzodiazepines.

38. I authorize my provider to provide a copy of this agreement to my pharmacy, other health care providers, insurance carrier and any emergency room, upon request. I give my permission to allow sharing of my medical history regarding medication use with other health care agencies/facilities.

39. I understand that my treatment plan and my compliance to this agreement will be reviewed annually or sooner if indicated by my provider and that I will participate fully and honestly with such a review and reactivation of the agreement/consent.

I understand that my provider may STOP prescribing my benzodiazepine if:

1. I do not show any symptom improvement.

2. I develop rapid tolerance to the benzodiazepine or if there is loss of effectiveness from the treatment.

3. I develop significant side effects from the medication.

4. I refuse to consent to a drug screening, or I am found to be using illegal substances (e.g., cocaine) or controlled medications prescribed by another provider or obtained illegally.

5. I fail to comply with any aspects of my treatment program as recommended by my provider, including but not limited to physical therapy, occupational therapy, and counseling.

6. I do not fulfill any of the responsibilities outlined above, which may also result in being discharged from care by my provider or InterMed.

7. I miss two consecutively scheduled appointments associated with the benzodiazepine medication or related condition(s).

8. My provider determines, for any other reason, that the benzodiazepine treatment is not advisable.

I have had an opportunity to read the above agreement and consent or have had it read to me. I have had my questions answered to my satisfaction. I understand and accept the risks, conditions, and terms of the proposed treatment as presented. I am signing this form voluntarily, and I have full right and power to be bound by this agreement.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Printed Name of Provider: _____

Cc: Primary Care Provider (if different than provider above): _____