NARCOTIC PRESCRIBING POLICY

1. The prescribing of narcotics for chronic pain is a challenge under the best of circumstances due to issues of substance abuse, addiction, legal requirements, the historical percentage of drug abusers intermingled with the chronic pain population and many other factors. The goal of our medical practice is to provide narcotics when deemed appropriate utilizing the guidelines of the Federation of State Medical Boards. In order to continue prescribing narcotics to patients, it is necessary to have tight controls and rigid rules established to eliminate those who procure narcotics for illegal purposes or for substance abuse, to protect privileges of our practice to prescribe, maintain the health and welfare of the patients and to obey the laws under which we operate, both federal and state.

2. Narcotics are but one avenue of pain therapy and **never** represent the sole method of pain control. Narcotics have potential for addiction and substance abuse, are diverted by some for sale of or improper routes of administration or are shared with others. Narcotics may produce dependence, tolerance and addiction. Side effects of narcotics include sedation, respiratory depression, swelling in the feet, dental decay acceleration, hives, itching, slurred speech, impaired thinking and function to the point a person may be dangerous when driving or operating machinery when taking narcotics, ICU admission, coma and death. For these reasons, we reserve the right to change to a non-narcotic therapy at any time it is medically indicated. We also reserve the right to insist on patient treatment for narcotic dependence. There is no implied or expressed patient right to narcotic therapy in our physician's office.

3. **EXPECTATIONS OF APPROPRIATED PATIENT BEHAVIOR AND RESPONSIBILITY**
   a) Our medical practice will be the only entity prescribing narcotics for chronic pain. If there is acute pain for a new condition for which the patient seeks care elsewhere, our practice must be called to let us know of the other physicians prescribing, and at that time we may adjust your chronic pain medications. If it is discovered patients are receiving narcotics from multiple physicians, we will immediately discontinue medication prescribing and notify pharmacies and other treating physicians of the patient's abuse.
   b) One pharmacy must be used for scripts. If that pharmacy does not have the prescription, then we will expect patients to go to another pharmacy rather than receive a partial refill on the narcotic. We will not write additional scripts to cover the balance of a shortfall from a pharmacy with insufficient supplies. Therefore in advance, ask the pharmacist not to fill the prescription with a partial refill if the pharmacy lacks sufficient stocks to carry out the prescription filling. If a second pharmacy must be used to fill a script of narcotics, then notify our practice at that time regarding the situation.
   c) Refills of a script for narcotics are only preformed during scheduled office visits. We will not call in narcotic prescriptions during non-office hours.

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d) There are no early refills. The patient is expected to make the prescription quantity last until the next office visit. We do not fill prescriptions that were lost, stolen, spilled, flushed, eaten by a cat/dog, etc. The responsibility for safekeeping of these medications lies solely with the patient. Therefore, each patient is expected to keep a lock box or location for safekeeping for the main supply of the narcotic medication instead of carrying around the entire month's supply.
e) On request of our medical practice, the patient will submit a urine or blood sample to a designated laboratory for testing to assure the medication being prescribed are actually in the urine. The patient has 24 hours in which to give the specimen. On request, a pill count may be necessary and the patient has 24 hours to bring in the narcotics to be counted by our staff.
f) There will be no alcohol or illicit drug use while taking narcotic medications. Discovery of such via internal or external sources may result in discontinuation of narcotics immediately.
g) It is the policy of our practice that driving or operating machinery while taking narcotics may have untoward consequences, and if the patient elects to operate machinery or equipment, they do so at their own risk or injury or death.
h) Sudden cessation of narcotics causes injury to the patient only in very rare circumstances. However, sudden cessation of high dose narcotics will results in severe abdominal cramping, severe anxiety, rapid heart rate, elevated blood pressure, nausea, etc. Therefore, it is prudent to sue the narcotics as prescribed rather than running out early or violation of our policies which will result in sudden cessation of narcotic prescribing.

4. **REASONS NARCOTICS MAY BE IMMEDIATELY DISCONTINUED**

Reasons for which narcotics will be stopped immediately and without any withdrawal medications include, but are not limited to: evidence of prescription alteration or fraud or solid evidence presented to our clinic that the patient has been selling narcotics, sharing narcotics with others, injection of oral or trans dermal narcotics, threats of legal action or violence made against any of our staff in order to obtain narcotics, etc.

Additionally, refusal to take a urine drug screen within 24 hours of the request, refusal to bring in medications for a pill count when requested, a positive drug test for illicit drug use or narcotics not prescribed by our clinic, or a negative urine drug screen for narcotics we are prescribing will be met with discontinuation of narcotics. External source confirmation of "doctor shopping" or obtaining narcotics chronically from multiple physicians simultaneously will require sudden narcotic discontinuation. Impairment of the patient to such a degree that in the opinion of our medical practice the patient poses a risk to themselves or to others may require narcotic discontinuation.

5. **REASONS NARCOTIC THERAPY MAY BE MODIFIED OR REDUCED**

Reasons for which narcotic therapy will be modified or discontinued with the possibility of a drug taper or non-narcotic withdrawal medication administration; lost or stolen scripts,

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overuse of medications, failure of escalation doses of narcotics to provide relief in the absence of any demonstrable worsening findings on clinical examination including X-rays/MRIs, excessively frequent calls to our clinic regarding chronic pain issues, prevarication regarding prior treatment and substance abuse, cancelling appointments for procedures but showing up for office visits or failure to participate in the integrated therapies of our practice.

6. Chronic pain is just that: it is a long-standing problem which has been present for months or years. It is important that patients keep a long-term perspective on the treatment of this condition. Frequent calls to our clinic for non-urgent issues or frequent requests of narcotics changes outside of appointment times may make patients non-candidates for continued therapy in our center. Calls made for non-emergent issues or issues which should be handled during office hours will jeopardize continued treatment in our practice.
7. For questions regarding our narcotic policy, call our office and ask to speak to the Practice Manager. The Modified Federation of State Medical Board Narcotic Prescribing Guidelines 2004 is used by our practice. Guidelines can be found below.

I, _____

HAVE READ AND UNDERSTAND THE PRESCRIBING POLICY ABOVE.

WITNESS: _____

DATE: _____

Initial: _____

Date: _____

Modified Federation of State Medical Board Opiate Prescription Guidelines

Evaluation of the Patient – A medical history and physical examination must be obtained, evaluated and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function and history of substance abuse. The medical record also should document the presence of one or more recognized medical indication of the use of a controlled substance.

Treatment Plan – The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment, modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

Informed Consent and Agreement for Treatment – The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should consider the use of written agreement between physician and patient outlining patient responsibilities, including urine/serum medical levels screening when requested, number and frequency of all prescription refills and reasons for which drug therapy may be discontinued (e.g., violation of agreement). ***Consent for narcotic treatment by our practice is given on the initial visit as part of the paperwork packet.***

Periodic Review – The physician should periodically review the course of pain treatment and any new information about the etiology of the pain of the patient's health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be monitored and information from the family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the physician should access the appropriateness of continuous use of the current treatment plan and consider the use of other therapeutic treatment.

Initial: _____

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Our medical practice's periodic patient reviews are usually as follows:

- Initial patients or patients experiencing changes in therapy have may reviews each month.
- Chronic stable patients receiving Schedule III medications (hydrocodone/codeine/Darvocet) opiate therapy in addition to physical therapy and psychological treatment where appropriate will be seen every 2-3 month for review.
- High risk patients or those with substance abuse history may be seen every week or more.
- Patients receiving Schedule II medications (oxycodone, Oxycontin, Duragesic, MS Contin, MS IR, Kadian, Avinza, dilaudid, methadone) will be seen in monthly intervals.

Consultation – The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse or diversion. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patient.

Medical Records – The physician should keep accurate and complete records to include the medical history and physical examination, diagnostic, therapeutic and laboratory results, evaluations and consultations, treatment objectives, discussion of risks and benefits, informed consent, treatments, medications (including date, type, dosage and quantity prescribed), instructions and agreements and periodic reviews. Records should remain current and be maintained in an accessible manner and readily available for review.

Compliance with Controlled Substance Laws and Regulations – To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and (any relevant documents issued by the state medical board) for specific rules governing controlled substances as well as state regulations.

Patient Signature: _____

Witness: _____

Date: _____

Initial: _____

Date: _____