Controlled Substance Treatment Agreement – Tip Sheet and Points of Clarification

• (Identify type of medication) _________________________ will be prescribed only by this provider (or provider’s representative). I will tell my other providers that I am receiving this medication from this provider.
  o The Agreement is specific to an individual provider. A separate agreement is needed for each provider prescribing controlled substances on a chronic basis.
    • It is not required that one provider prescribe all controlled substances for the patient. There may be one prescriber for chronic opioids, another prescriber for chronic benzos, and yet another prescriber for chronic stimulants. While these could all be the same provider, it is not required.
    • Most important is that all prescribers are aware of each other, and don’t overlap with the meds or med classes they are prescribing.

• The risks, benefits, and other options for treatment will be reviewed by this provider.
  o The Agreement cannot replace direct communication between provider and patient.
  o Use of an Agreement does not equal informed consent. There are several ways to approach informed consent:
    • Engage patient in a discussion of the risks vs. benefits of treatment.
    • Use a patient education sheet to supplement your discussion of risks vs. benefits. Examples of information sheets for adult patients are available on the Pain and Opioid Toolkit LibGuide (under the tab labelled Informed Consent), or you could create your own.
    • Create a separate written “informed consent” that is specific to the particular risks vs. benefits of the substance being prescribed.
  o No matter what approach you use, expect that patients typically do not remember all of the information so reinforcement at follow-up visits will be necessary.
  o Informed consent must be documented in the EHR.

• I will not use recreational drugs, substances, or any medication not prescribed to me.
  o Always include discussion of the benefits and risks associated with OTC medications.
  o Questions often arise about patient use of cannabis, specifically how to approach ongoing use with patients on controlled substances.
    • With the exception of Cannabidiol Oil, cannabis remains illegal in Wisconsin. There should be clear documentation that the clinician has notified the patient that use of cannabis is currently illegal in Wisconsin and has encouraged the patient to quit using.
    • In 2016, the amended CDC guideline acknowledged there might be uncertainty about the clinical implications of a positive urine drug test for THC. Since most urine drug test panels include THC, providers should have an approach to how positive results will be addressed.
• Application of these guidelines in the context of cannabis use may be subject to individual interpretation and subject to change, given the evolution of this substance’s place in society both culturally and medically.

• I will be given a prescription to last a fixed amount of time. I will not use more medication than prescribed. I will not ask for early refills.
  o Consider a 28 day refill interval. This allows for refills to be consistently on the same day of the week, minimizing the likelihood of patients running out of medication on the weekend.

• Breaking any of these rules may result in my provider no longer prescribing controlled substances to me and could result in my removal from the practice.
  o A violation of the Agreement may result in discontinuation of controlled substances but should not automatically discharge a patient from the clinician’s practice.
  o The Medical Examining Board guideline explicitly states, “Discharging a patient from the provider’s practice solely due to an opioid use disorder is not considered acceptable. “
    • (MEB) “All practitioners are expected to provide care for potential complications of the treatments they provide, including opioid use disorder. As a result, if a patient receiving opioids develops behaviors indicative of opioid use disorder, the practitioner, when possible, should assist the patient in obtaining addiction treatment, either by providing it directly (buprenorphine, naltrexone, etc. plus behavioral therapy) or referring them to an appropriate treatment center or provider willing to accept the patient.”
  o Agreement violations should prompt further evaluation for potential under-management of pain (pseudoaddiction), mental health disorder e.g., depression or anxiety, or substance use disorder. This evaluation will also help determine need for patient education, enhanced monitoring, change in treatment plan, discontinuation/taper of controlled substances, or referral for proper AODA support.
  o A single aberrant drug-related behavior does not imply abuse; multiple aberrant behaviors reveal a pattern suggestive of abuse.
  o Aberrant drug-related behaviors vary in seriousness. In the case of illegal activity such as prescription forgery, selling prescriptions, abusive or threatening behavior toward staff, or any behavior that irrevocably damages the patient-provider relationship, dismissal from the clinic may be required.