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Benzodiazepine Therapy Agreement & Consent

This document is an agreement between patient and physician regarding the use of benzodiazepines, a class of medications that are 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.

I_____DOB:_____(patient receiving benzodiazepine medication) have agreed to use this medication as part of my treatment. My provider is prescribing this medication to me for a diagnosis of:
_____.

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

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

-drowsiness	-dizziness	-blurred vision	-headache
-poor concentration/confusion	-impaired coordination	-memory loss	-grogginess
-fatigue	-stomach upset	-depression	-subtle personality changes
-dreaming/nightmares	-muscle weakness	-abuse/death	-psychological addiction

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 benzodiazepines 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 themselves.

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 treating 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.

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 and high blood pressure, insomnia, abdominal cramps, tremors, diarrhea, muscle or bone aching, seizures), which may occur in 24-48 hours of last dose. Withdrawal symptoms are usually self limited but could, in rare cases, be life threatening and may require hospitalization.

_____(patient initials)

I understand that psychological addiction is a possible risk to the use of benzodiazepines. Addiction is recognized when an individual abuses a drug to obtain mental numbness or euphoria; when an individual shows a drug craving behavior, visits multiple doctors and pharmacies in pursuit of a medication or shows a manipulative attitude towards the provider in order to obtain the drug. Addictive behavior is reason for the drug to be tapered and discontinued.

- 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 therefore classified as class D teratogens. 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.

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

Because these drugs have the potential for 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.

Rules of Benzodiazepine Therapy Agreement

I understand that I have the following responsibilities:

1. 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.

2. 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).

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

4. I will keep my medications and prescriptions in a secure, safe place (preventing others access to these medications).

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

6. Timely requests (two business days) for refills are my responsibility. Refills of my prescriptions for benzodiazepines will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends. In accordance with state law, prescriptions must be ordered by my provider electronically (e-prescribed) and will not be mailed.

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

_____(patient initials)

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

9. I will not share my medication with anyone.

10. Renewals are contingent upon me keeping scheduled appointments and following prescription directions. I understand that my prescribing provider will want to review my benzodiazepine prescription with me at least annually during an office visit.

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

12. 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.

13. 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.

14. 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.

15. I will inform my provider of all other medications I am taking, to include over-the-counter, herbal, and prescribed medicines.

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

17. 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.

18. I will not use street drugs or another person's prescriptions. I will not use alcohol while taking this medication. I will inform my provider of alcohol or drug use, past or present, as well as any history of alcoholism or addiction. 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.

19. Should my provider deem it appropriate, I consent to random blood or urine drug screenings to assure that I am taking only prescribed drugs. I understand that all out-of-pocket expenses associated with drug screenings will be my responsibility.

20. I consent to random 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 number of pills.

21. 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/inappropriate use of my benzodiazepines.

_____(patient initials)

22. 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 in regard to medication use with other health care agencies/facilities.

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

    a. I do not show any symptom improvement.

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

    c. I develop significant side effects from the medication.

    d. 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.

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

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

    g. I miss two consecutively scheduled appointments with my provider.

    h. If my provider determines, for any other reason, that the benzodiazepine treatment is not advisable.

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

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's Signature:_____

Date: _____

Signature of Provider Obtaining Consent:_____

Date:_____

Printed name of Provider:_____

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

_____

Patient Name: _____ DOB: _____

Annual Benzodiazepine Therapy Agreement Review and Renewal:
By signing on the appropriate year row below, we attest that we have re-read the above agreement and continue to agree to abide by the content.

Date Signed	Patient Signature	Provider Signature