OBHAW Controlled Substance Prescribing Policy

OBHAW has implemented a *Controlled Substance Stewardship Program* to promote safe, evidence-based prescribing of medications regulated under the federal Controlled Substances Act (CSA) and overseen by the U.S. Drug Enforcement Administration (DEA). This policy update, effective immediately, applies to all psychoactive controlled medications, including, but not limited to, benzodiazepines, sedative/hypnotics, stimulants, and buprenorphine.

OBHAW providers prescribe controlled medications only when clinically appropriate and may reduce, taper, discontinue, or decline to prescribe them at any time based on clinical judgment, patient safety concerns, Prescription Drug Monitoring Program (PDMP) findings, medication misuse or diversion concerns, or current prescribing standards.

Client Responsibilities and Treatment Expectations

1. I understand that OBHAW providers routinely review the Arkansas Prescription Drug Monitoring Program (PDMP) and other available records to ensure safe prescribing practices. Concerning findings, including, but not limited to, overlapping prescriptions, multiple prescribers, early refills, pharmacy or provider "shopping," unsafe medication doses or combinations, or a history or presence of substance use, may result in reassessment, reducing or tapering doses, discontinuation of medications, referral to a higher level of care, collaboration with my outside providers, or discharge from medication management services. _____
2. Once enrolled in medication management services, only my OBHAW provider will determine the necessity to continue psychoactive controlled medications, despite how long I may have already been taking them. It is at the discretion of my OBHAW provider to determine if these medications are clinically indicated and appropriate for my treatment. If the medications are concurrently treating me for non-psychiatric conditions, my OBHAW provider may choose to be the sole prescriber for them, or they may choose to allow my outside provider to continue prescribing them. It is my responsibility to notify my outside providers regarding this policy once I am an established patient at OBHAW. If my outside providers continue to prescribe psychoactive controlled medications, it is my responsibility to refuse obtaining these medications from my pharmacy, and I am equally liable for anyone else who may try obtaining medications on my behalf. Failure to comply may result in reassessment, reducing or tapering doses, discontinuation of medications, referral to a higher level of care, collaboration with my outside providers, or discharge from medication management services. _____
3. I agree to take medications exactly as prescribed. I understand that altering the timing, frequency, dose, or method of administration without approval from my OBHAW provider may result in reassessment, reducing or tapering doses, discontinuation of medications, referral to a higher level of care, collaboration with my outside providers, or discharge from medication management services. _____
4. Early refills, replacement prescriptions, bridge prescriptions, or emergency supplies will not be provided for medications that are lost, stolen, destroyed, taken more frequently than prescribed, or otherwise unavailable before the authorized refill date. _____
5. I am responsible for protecting my medications from loss, theft, or misuse. _____

6. OBHAW may request scheduled or random urine drug screens, pill counts, pharmacy verifications, or coordination with outside providers or pharmacies to ensure safe prescribing practices. _____
7. Evidence of alcohol misuse, illicit substance use, diversion concerns, unsafe medication combinations, or other safety concerns may result in reassessment, reducing or tapering doses, discontinuation of medications, referral to a higher level of care, collaboration with my outside providers, or discharge from medication management services. _____
8. I agree to attend scheduled appointments and actively participate in all treatment recommendations from my OBHAW provider, including therapy or counseling when indicated. Failure to comply may result in reassessment, reducing or tapering doses, discontinuation of medications, referral to a higher level of care, collaboration with my outside providers, or discharge from medication management services. _____
9. I understand that counseling and therapy are important components of treatment for depressive disorders, anxiety disorders, traumatic stress disorders, panic disorders, obsessive-compulsive disorders, phobic disorders, personality disorders, and substance use disorders, and that medications alone are not considered sufficient treatment. _____
10. I understand that any changes I make in the administration of my psychoactive controlled medications, including, but not limited to, abruptly discontinuing or reducing doses, taking more frequently or at increased doses, or taking them in conjunction with opioids, alcohol, or other illicit substances, will alter their physiologic characteristics in my body and may result in seizures, cardiac complications including heart attacks, respiratory depression, severe withdrawal, mania, psychosis, or death. _____
11. If my OBHAW provider determines that my psychoactive controlled medications can no longer be safely managed in an outpatient setting, I may be referred to addiction medicine services, detoxification services, inpatient treatment, or another appropriate level of care. _____
12. Understanding that my provider will recommend a safe, effective, and evidence-based treatment plan despite my personal beliefs on which medications and doses I should or should not take, I am expected to communicate respectfully with all providers, staff, and employees at OBHAW. Threatening, abusive, manipulative, or disruptive behavior will result in permanent discharge from OBHAW and immediate discontinuation of all medication management services, with any further treatment determined solely at the discretion of the medical director. Should this occur and result in worsening psychological and/or physical symptoms, it is my responsibility to go to the nearest hospital or contact emergency medical services by dialing 911. _____

I understand that psychoactive controlled medications are prescribed at the discretion of my treating provider at OBHAW and that continuation of treatment is not guaranteed. I acknowledge that I have had the opportunity to ask questions regarding the risks, benefits, alternatives, and expectations related to treatment with psychoactive controlled medications.

I have read and understood this agreement, and I agree to comply with these treatment expectations.

Client/Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____