Controlled Substance Agreement

In 2019, we revamped out controlled substance agreement to be educational. We're continuing to use this version for any new patients needing an agreement and/or anyone we missed first time through in 2020.

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Dear Patient,

Our records indicate that you receive a prescription from us for a Schedule II-IV medication. Several more changes in how these are being monitored were signed into place by the outgoing governor that will require a change in how these prescriptions are obtained (I am not sure if it will change with a new governor, but it likely will not). DON'T PANIC! We have a plan! BUT don't blow this off either.

The other issue is that 2017-2018 were years of a record number of patients "forgetting" the rules of our agreement. These were patients I have known for as long as 20+ years without any prior history of behavior suggestive of diversion, so I did not believe there was an issue. BUT I do believe many have taken this policy for granted and have developed a "laxity" in their respect for the danger these medications can manifest.

Therefore, I have revised our agreement to cover all Scheduled II-IV medications. I have included an educational portion and a quiz in this packet.

Schedule II	These have a high potential for abuse which may lead to severe psychological or physical dependence.	Examples: hydromorphone (Dilaudid), methadone (Dolophine), oxycodone (OxyContin, Percocet), fentanyl (Duragesic), amphetamine (Adderall), lisdexamfetamine (Vyvanse), methylphenidate (Ritalin)
Schedule III	These have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.	Examples: Tylenol with Codeine, buprenorphine (Suboxone), anabolic steroids (Testosterone)
Schedule IV	These have a low potential for abuse relative to substances in Schedule III	Examples: alprazolam (Xanax), carisoprodol (Soma), clonazepam (Klonopin), clorazepate (Tranxene), diazepam (Valium), lorazepam (Ativan), temazepam (Restoril)

Table 1

Beginning in 2020, we also will have to tie all scheduled medications to a diagnosis code, so we are going to need to establish in 2019 why you take them. Some diagnosis codes are going to be excluded. For example, "chronic pain" is not an acceptable code per this new legislation. It must include a disease or anatomical location (see below table for some examples):

Not Acceptable	Acceptable
Chronic Pain Syndrome	Osteoarthritis, multiple sites
Chronic Post-Operative Pain	Osteoarthritis, bilateral knees
Chronic Pain	Failed Back Surgery
Chronic Migraine	Occipital Neuralgia
	Post-Herpetic Neuralgia

Table 2

So, pain patients need to keep this in mind when you fill out the Brief Pain Inventory this year. I must also document that I reviewed your filling history of scheduled medications, via the Illinois State Prescription Monitoring Program website, with you.

*For pain patients: how often I have to see you and do this is directly going to be based on your daily MME (Morphine Milligram Equivalent). This will also be discussed and calculated.

*For ADD and ADHD patients: we will have you take the newest AMEN ADD typing questionnaire. Stimulant recipients also have to have documentation that we have reviewed the filling pattern yearly as well but we're going to tackle the stimulants next quarter.

Sometime this year, you also will be asked to submit a urine sample, and it will be done in a random fashion. Before you submit your urine sample, you will need to tell us the following information:

1. When you last took your controlled medication prescription
2. It is better to confess up front any indiscretion than for us to find it in your results
3. Those on synthetic opiates will be given a test that can detect their specific medication, and it definitely costs more, but it is required.

In order to get all of this paperwork done, you will need to schedule your next refill appointment as a POV (30 minute appointment) rather than a GO (10 minute appointment, these are available at the end of the day). That is why I am sending this to you ahead of time if we have your email in the system.

This also brings up another reminder…GO appointments are for refilling medications that are NOT being changed. If you want to change your dosage or quantity, then you MUST make a regular POV appointment. A GO appointment is only for one objective, therefore GO refill appointments will ONLY be for refills and failure to comply with this can land you on the no-Go list.

To save everyone time, I'm sending you this new agreement ahead of time, so you can read it, study it, sign it, and take your quiz. We will have plenty of copies in the office if you leave it at home, but at least you should be familiar with it.

Failure to read everything ahead of time, and be ready for the visit, may require rescheduling if you cannot get it done in your time slot, and this may result in you not receiving your prescriptions on time.

Please assist us to make this process as smooth as possible for all of us!

Thank you for your cooperation!

Dr. Rebecca Knight

To recap by schedule level (see Table 1 for definitions and examples of each schedule):

Recipients of Schedule II pain prescriptions:

1. Read, sign, and initial agreement
2. Take quiz
3. Figure out your MME, if I haven't already for you
4. Do Brief Pain Inventory
5. Make a POV appointment (30 minute) for your next refill to go over this
6. MME
    a. If <60, you can get your refills in a GO every 3 months after your initial POV this year
    b. If 60-120, you need to refill every 3 months in a POV and review IL Prescription record at each visit
    c. >120 OR 60-120 and on a benzodiazepine, you need monthly POV for refills until this is below 120. Otherwise you will be required to stay at monthly visits, or see a pain specialist (and you will be prescribed Narcan and will require family training in administration)
7. Anyone wanting to taper down or off a scheduled medication, I need 2 weeks notice or your can return to the office 2 weeks later in a GO appointment for a taper schedule and prescriptions.

Recipients of Schedule II stimulants:

1. Read, sign, and initial agreement
2. Take quiz
3. Do new AMEN ADD typing if you haven't done in our office yet (we started doing these in December 2018, so a few of you have this already done)
4. Make a POV appointment (30 minute) before you are due to run out of medication
5. Feel free to mail or drop off your papers ahead of time so you do not lose or misplace them
6. Do not miss your POV, or it will cost you $100 (same applies to everyone, but I know this is especially difficult for us AD/HDers!

Recipients of Schedule III medications

1. If you are on testosterone and male
2. Read and sign agreement
3. Take quiz
4. You are to be having labwork every 6 months in order to stay on testosterone
5. Goal to keep safe is to keep levels between 500-700
6. If you use gel, avoid elbow area as it can inaccurately increase your level when blood is drawn from there
7. Ideally your lab should be drawn 24 hours after dose, and in the morning

Recipient of Schedule IV medications (and not on any pain medications):

1. Read and sign agreement
2. Read and sign consent with Anxiety & Sleep Medication booklet (enclosed)
3. Make POV for next refill to discuss this and only this; it cannot be combined with another appointment
4. If you want to try to taper down or off, I need 2 weeks notice ahead of your appointment (but if you ask about this at your POV, you can come back for a GO in 2 weeks to get your new prescriptions and titration schedule

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2019 CONTROLLED SUBSTANCE EDUCATION AND AGREEMENT

This document is for establishing an agreement between the (patient) _____, and the Knight Center for Integrated Health (Dr. Knight), on the clear conditions for the prescription and use of controlled substance medications. This agreement is an essential factor in maintaining the trust and confidence necessary in the doctor/patient relationship. Violation of this agreement is a violation of trust and may result in termination of the patient/doctor relationship. It is also put in place for your safety, as well as mine, and to guarantee that patients with legitimate needs for controlled substances, also known as scheduled drugs, can still obtain them without a reason to doubt that they are being used appropriately.

Over this last year, I have noticed that many patients on scheduled drugs, both pain medications and others such as stimulants, clearly did not really read this document or understand it. Therefore, I'm going to first provide some education and require this agreement for all patients that are receiving Schedule I-IV. There will also be an "open-book" quiz at the end.

Drugs, substances, and certain chemicals used to make drugs are classified into five (5) distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential. The abuse rate is a determining factor in the scheduling of the drug; for example, Schedule I (1) drugs have a high potential for abuse and the probability to create severe psychological and/or physical dependence. As the drug schedule increases in number (Schedule II (2), Schedule III (3), Schedule IV (4), etc.), so does the abuse potential—meaning Schedule V (5) drugs represent the least potential for abuse.

Schedule I

Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse. Some examples of Schedule I drugs are:

-heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), 3,4-methylenedioxymethamphetamine (ecstasy), methaqualone, and peyote

Schedule II

Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. Some examples of Schedule II drugs are:

-Combination products with less than 15 milligrams of hydrocodone per dosage unit (Vicodin), cocaine, methamphetamine, methadone, hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin), fentanyl, Dexedrine, Adderall, and Ritalin

Schedule III

Schedule III drugs, substances, or chemicals are defined as drugs with a moderate to low potential for physical and psychological dependence. Schedule III drugs abuse potential is less than Schedule I and Schedule II drugs but more than Schedule IV. Some examples of Schedule III drugs are:

-Products containing less than 90 milligrams of codeine per dosage unit (Tylenol with codeine), ketamine, anabolic steroids, testosterone

Schedule IV

Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence. Some examples of Schedule IV drugs are:

-Xanax, Soma, Darvon, Darvocet, Valium, Ativan, Talwin, Ambien, Tramadol

Schedule V

Schedule V drugs, substances, or chemicals are defined as drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics. Schedule V drugs are generally used for antidiarrheal, antitussive, and analgesic purposes. Some examples of Schedule V drugs are:

-cough preparations with less than 200 milligrams of codeine or per 100 milliliters (Robitussin AC, Cheratussin), Lomotil, Motofen, Lyrica, Parepectolin

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The stimulants in the Adderall and Ritalin family are Schedule II drugs, just like Morphine, Oxycodone and Hydrocodone. Should they be? That is not up to me.

One of the most important concepts that many clearly don't understand is that these drugs cannot be "called in," "faxed in," nor "sent in electronically." ADD stimulants were never in a category that could be called in, but people still call and ask for a refill to be sent to their pharmacy. The only way these medications will get to your pharmacy is when you carry your prescription into the pharmacy by hand. E-scribing is available in Chicago and maybe available here in the future, but it's not here yet, so, until further notice, you must have a physical prescription in your hand to get this medication from the pharmacy.

The reason they are called "controlled" is that we are trying to limit the number that make it to the street and into the hands of people that were not prescribed the medication. This means you can't share them with your family members or a friend. If we find out that you gave them away, that will mean you are in violation of this agreement. Selling them is obviously a criminal offense and will be reported to the police. I previously reported a prior employee and had her arrested from my office for prescribing hydrocodone for herself and four other people not under my care. So, you had better believe that I will not hesitate to report any illegal activity once I am aware of it.

Considering "The Opioid Epidemic", there is now a limit to how many controlled substance medications pharmacies can have on hand. They will no longer have a stock pile on a shelf, which unfortunately means you may have to take your prescription to another pharmacy to get it filled. This used to be discouraged before we had electronic means of tracking your prescription fills, but now is no longer a concern. All these medications are reported to the state and we can see where you fill them, who prescribed them and if you fill them early. That brings up a new requirement in the State of Illinois. Governor Rauner signed a bill stating that we must check your filling habits at least yearly, or more often for those on an opiate that have a daily morphine milligram equivalent (MME) of greater than 60 mg. We are starting this effective immediately since you are now aware of it with signing this agreement. If you have any issues you think we should be made aware of before we review the report, remember that it is ALWAYS better to ask permission, but if it's too late, it will be better to confess before being caught.

I believe the next phase of the controlled substance monitoring that will be arriving soon will be limiting the amount of pain medication primary care physicians can prescribe to less than 120 MME per day, possibly less than 60 MME and not being able to take both an opiate and a sedative-hypnotic together.

What this means is that we will calculate your MME today if you take any narcotics (Appendix 1, page 9). The following table will be used for the conversion.

MME Conversion Table

Opioid (doses in mg/day except where noted)	Conversion Factor
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone (I refuse to prescribe this drug for this reason)	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

Target Dose MME to be less than 120 MME to be prescribed by non-pain medication specialist.
Target Dose MME to be less than 60 MME if also taking a sedative-hypnotic but they could also just refuse to allow them to be taken together.

Sedative-hypnotics:
Xanax (alprazolam), Ativan (lorazepam), Valium (diazepam), Klonopin (clonazepam), Restoril (temazepam), Ambien (zolpidem), there are more but this is a sample.

Since October 6, 2014, hydrocodone was changed from III to II and was no longer able to be called in and I believe it was a wise move. The biggest reason I think this was a good idea is that rendered it impossible for nurses to call in hydrocodone and I believe that ability to do so was one of the reasons it was so widely abused. It also gave the mistaken impression that hydrocodone wasn't as addictive as the other opiates and that was a mistake. There are plenty of healthcare professionals addicted to hydrocodone for the very simple reason that they could call it in.

To do this, they had to open it up for public comment. Per the DEA website, 52% of all commenters (298 of 573 comments) supported, or supported with qualification, controlling hydrocodone combination products (HCPs) in schedule II of the Controlled Substance Act (CSA). The majority of those supporting the rule were members of the public and physicians. Comments submitted by the general public comprised 62% of the total 298 comments that supported, or supported with qualification, the rescheduling. Seventy-four percent (74%, or 184 of 250 comments) of all comments submitted by the general public were in support, or supported with qualification, the rescheduling. Comments by physicians comprised 14% of the total 298 comments that supported or supported with qualification rescheduling. Fifty-six percent (56%, or 41 of 73 comments) of all comments submitted by physicians were in support, or supported with qualification, rescheduling.

Just to make sure you understand where I stand, I wrote a comment as a physician in support of this proposed rule for the very reasons I listed above. Having been a victim of a member of my own staff prescribing her own hydrocodone, I was completely in support of this measure. I just looked this up for the first time and was shocked that I was one of only 73 comments, but doctors are busy people I guess. If I happen to see any legislative group wanting feedback and I have an opinion, then I'm there.

Forty-one percent (41%) of commenters (235 of 573 comments) opposed the proposal to reschedule HCPs from schedule III to schedule II of the CSA. The majority of those opposed to rescheduling HCPs were

pharmacists, pharmacy students, and ultimate users. Pharmacists and pharmacy students comprised 31% of the total 235 comments submitted in opposition to the rule. Sixty percent (60%, or 122 comments) of all comments submitted by pharmacists and pharmacy students were in opposition to the rule. Comments from ultimate users comprised 14% of the total 235 comments in opposition to the rule. Ninety-one percent (91%, or 32 of 35 comments) of all comments submitted by ultimate users were in opposition to rescheduling.

So, you thought pharmacists cared? Hah! OK 40% of the pharmacist and pharmacy students that commented supported it, but still… (and who knows, they may have been calling in their own as well!)

I support it because I feel we all need regulations so that we know when addiction has taken over the reins and the person is no longer acting appropriately. How else will we know? I also support the legalization of all drugs, even Schedule I. I believe addiction is a disease and should be treated as such, but making it a crime to obtain only makes drug dealing a profitable, although risky, endeavor and perfect line of work for gangs and drug cartels. However, just because I feel that way does NOT mean you will be able to test positive for cocaine and get your hydrocodone prescription. If you have a cocaine problem and tell me up front that you went through a rehab program, then I MAY be willing to write a controlled substance, but I will monitor you like I do my gluten free chocolate chip cookies, and I will know when you slip up. I do it because I care. I am not here to treat your addiction as I've not done the training. I don't have a license to prescribe suboxone and do NOT anticipate getting one any time soon. I have enough on my plate treating environmental toxins like borreliosis and Mold toxins that no one else in town will touch. If you are interested in suboxone, I recommend Dr. George Gilbert or Dr. Glen Feather. I believe you can also get suboxone and methadone from The Rose Medical Associate and Central Illinois Center for the Treatment of Addictions.

About 10% of people that take an opiate will have a much more euphoric experience then the rest of us and therefore be much more likely to develop an addiction. You have a higher likelihood of having this reaction if you have other people in your family that suffered from addiction, and depression is also associated with this tendency. Not everyone that develops an addiction starts off this way, but most do.

I also had a patient voice concern over the wasted money on Narcan that the police and EMTs now carry to resuscitated heroin addicts. To this person, and anyone else that holds this belief and sees me regularly to get a prescription opiate, I have news for you: It's for you just as much.

From the same DEA website about rescheduling hydrocodone: Contrary to statements made by some ultimate users, even low doses of HCPs have the potential for adverse impacts on the public health and safety. According to the Centers for Disease Control and Prevention (CDC), while an estimated 80% of patients who are prescribed opioids are prescribed low doses (<100 mg morphine equivalent dose per day) by a single practitioner, these patients account for an estimated 20% of all prescription drug overdoses. An estimated 10% of patients who are prescribed opioids are prescribed high doses (>=100 mg morphine equivalent dose per day) by single prescribers. These patients account for an estimated 40% of all prescription opioid overdoses. An estimated 10% of patients are patients who seek care from multiple doctors and are prescribed high daily doses of opioids. They account for another 40% of all opioid overdoses.

So, are you wondering what is responsible for the most drug overdoses? The answer is prescription opioids! I had two patients die in 2017 that were on long term opiates, and I know for sure that one was an overdose, and I suspect the other one was as well. In 2015, drug overdoses accounted for 52,404 deaths (17,536 were from prescriptions and 12,989 from heroin). Heroin overdoses are on the rise at a faster rate than prescriptions, but don't be fooled into thinking these drugs are so much safer; they are not. They are just as dangerous when they're used by addicts. Nearly 80% of Americans using heroin (including those in treatment) reported misusing prescription opioid prior to using heroin.

How about this data. The US accounts for 99% of world's hydrocodone use and 80% of the world's oxycodone use. Where does all the opium come from to make these drugs? Asia and the Middle East.

I cannot predict accurately who will become an addict, but I can institute measures to reveal addiction issues quickly. However, even with those in place, I obviously had two people in my care die and that troubles me greatly. That is why I am revamping our program to make sure EVERYONE is aware of the potential problem and understands that the seriousness of these medications should NOT be taken lightly. I did NOT prescribe the medications for the one that I'm sure overdosed, their orthopedic doctor did, but I didn't oppose it, even though the patient had a history of addiction, because of the terrible injury that they suffered. That is a terrible position to be in. The other one, as I said, I do not know the cause of their death. I also had a patient that had an accidental overdose due to a faulty Fentanyl patch. The patch didn't stick well, and so they had it covered with tape as MOST Fentanyl patch wearers do. This patient was walking up and down Moss Avenue for the sidewalk sale and it was very hot, so they absorbed much more than usual and died in their sleep. Their family sued Mylan, the makers of the patch, but it was probably as a part of a bigger class-action suit and I never heard how it ended. You need to be aware of your risk, so I'm informing you with this agreement.

I haven't had anyone die from a stimulant. I was able to find that there were 15,514 psychostimulant-related deaths recorded over the eleven-year period of the study (which was impossible to find which years). There was a big drop in deaths when they made it so difficult to get Sudafed until mid-2009. Around mid-2009, Mexico started making and exporting Methamphetamine to the US and domestic "home" labs restarted. So, the reprise was only brief. Rural areas are still the heaviest users. Most deaths occur in males in the 45-54 age group, but that was the highest rate age group in women as well (I'm betting it's cardiac issues). However, these are all about illicit Methamphetamine use.

Deaths from sedative-hypnotics are on the rise and especially when they're taken in combination with opiates.

One last interesting fact, withdrawal from opiates doesn't kill anyone, but when they restart them it's easy to overdose. THIS IS WHY YOU MUST NOT TRY TO TAPER OFF YOUR OPIATES WITHOUT MY KNOWLEDGE AND HELP. AND WHATEVER YOU DO, DON'T GO BACK UP ON YOUR DOSE! However, alcohol and benzodiazepine (benzo) withdrawal can be deadly. So, I ask that those on sedative-hypnotics read my guide to those drugs and must PROMISE to not try and get off them without my help. I have successfully tapered people down in dose, off opiates, off benzo's, and off both. BUT I must stress you are <u>not</u> to do this on your own! Doing this is a violation of your agreement. This was not stated before, so you were not aware, but starting in 2019 you have been warned.

Abusing your prescribed drugs is also a violation of your agreement and can result in a termination of our relationship and thus an acute absence of your medications. This is very dangerous, and I highly recommend NOT doing it. BUT once I know that it's being diverted or misused, I have an ethical responsibility to NOT be an illicit drug dealer, so I will recommend you enter a drug detoxification program immediately. However, your disease is a disease only <u>you</u> can get help for, and I'm absolved of responsibility once it is discovered that this is the problem. Now you are also forewarned.

Stimulants (prescription) can be stopped cold-turkey without any harm or foul. You're just in danger of sleeping more and eating everything not nailed down for a couple of days, BUT they can certainly be abused and are the most abused drugs now on college campuses. From 1990 to 2000, 186 deaths in the US were linked to Ritalin. That's a far cry from opiates but it's not zero.

Anyone with children and young adults in their home need to be aware of the rising trends in prescription drug abuse, and owes it to their kids and their kids friends to keep them safe by keeping their medications locked up. I know my daughter is at the age that I worry about them finding meds and trying them at

sleepovers. So, we're having that talk when my materials I ordered come in. Studies have showed that kids that use Ritalin are at risk of using drugs of abuse, BUT kids that have ADHD are also at higher risk of drug abuse when untreated. It's very important that we identify the kids that benefit from stimulants and teach them to keep their medications safe. The penalties for a first trafficking offense (which you would be guilty of even if you just shared one or two pills with a friend) includes up to 20 years in prison and a fine of up to $1 million. These drugs are dangerous when they are not used properly. The punishment goes up if they snort it or inject it, and it results in serious injury or death. You don't want this on your head, never mind having a crime record.

Drugs used properly shouldn't kill anyone, but it's when they are misused or diverted that they can. There is a reason when you see a commercial for a drug that one of the side effects listed is often death. You think over the counter drugs are different, but they are not. Some of the deadliest drugs are Tylenol (acetaminophen), aspirin and ibuprofen. When these are taken by kids who want to overdose and show their parents, they couldn't have picked more deadly drugs. So, we need to educate our children.

Why do people take drugs (that they don't need)?

- To fit in
- To escape or relax
- To relieve boredom
- To seem grown up
- To rebel
- To experiment

They think the drug will be the solution, but soon it is the problem. It's hard to face your problems, but the consequences of drug abuse are ALWAYS worse than the problem one is trying to solve with them. Remember for some people alcohol in moderation improves their health, but for many it's the worst thing they ever could have tried. So, we must tell our kids to be careful out there because MOST drug abuse starts in kids. I am sure any smoker asked would rather their kids never smoked.

THE CONTROLLED SUBSTANCE AGREEMENT

The patient agrees to and accepts the following conditions for the prescription of a controlled substance prescribed by the doctor for the patient:

*I understand that a reduction in the intensity of my pain and improvement in my quality of life are the goals of this program. All these medications with long term use will lead to dependence and withdrawal symptoms if stopped abruptly. **So, appointments for refills should always be made on the day you receive your prescription.** This enables us to move your appointment up if I am going to be out of town or at a meeting. Failure to make your appointment could result in not being able to get a prescription if you wait until the last minute to make your appointment. _____ (initial and date)

*I realize that all medications have potential side effects, and I will have the recommended laboratory studies required to keep the regimen as safe as possible. I will at least once a year and possibly randomly be asked to do a urine specimen to document the presence of my medications in my system and the absence of contraindicated medications/recreational drugs. _____ (initial and date)

*I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there are any questions of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until myability to perform the activity has been evaluated, or I have not used my medication for at least four (4) days. _____ (initial and date)

*I will not use any illegal recreational substances, such as cocaine and will be honest if I have used them in past and tell my physician. _____ (initial and date)

*I will not share, sell, or trade my medication for money, goods, or services. _____(initial and date)

*I will not attempt to get any pain medication from any other health care provider without telling them that I am taking pain medication prescribed by Dr. Knight. I understand it is against the law to do so. If another doctor wants to prescribe pain controlling medication, Dr. Knight will have to approve the arrangement to make sure there is no duplication. This includes medications from the ER, dentist, foot doctor and so on.
_____ (initial and date)

***I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time. Lost or stolen pain medications will not be replaced regardless of the circumstances.** _____ (initial and date)

*I agree THAT ALL OF MY REFILLS WILL BE OBTAINED AT MY REGULARLY SCHEDULED APPOINTMENTS THAT I WILL MAKE UPON LEAVING FROM MY LAST ONE. IF I AM HAVING
MORE PAIN I WILL CALL AND MAKE APPT TO COME IN TO DISCUSS BUT I WILL NOT INCREASE MY USAGE OF MY MEDICATION WITHOUT DISCUSSING WITH DR. KNIGHT FIRST. FAILURE TO DO SO COULD RESULT IN MY HAVING DAYS WHERE I WILL RUN SHORT AND THAT IS A CONSEQUENCE OF MY NOT FOLLOWING DIRECTIONS AND THEREFORE I'M RESPONSIBLE FOR ANY ILL EFFECTS. _____ (initial and date)

*I agree that if I'm having problems with adherence of a pain patch I will use tape along the edges only of the patch and will attempt that before replacing earlier. If I have a batch that I have trouble with adhesive I need to come in and show the problem patches to the office staff and/or Dr. Knight. I will bring my pill bottles or boxes to all my appointments for refills. _____ (initial and date)

*I agree to waive any applicable privilege or right of privacy or confidentiality with respect to prescribing of my pain medication, and I authorize the Doctor and my pharmacy to fully cooperate with any city, state, or federal law enforcement agency, including the Illinois Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize the Doctor to provide a copy of this agreement to my pharmacy. _____ (initial and date)

***I agree to submit to a blood or urine test, annually & if requested by my Doctor at any time, to determine my compliance with my regimen of pain control medication.** _____ (initial and date)

***I agree to keep any appointments made and that I may need to be seen every 1-3 months for prescription refills and monitoring. I agree that I will make an appointment for a longer time slot (we call it a POV) if I want to change either my type of medication or the dosing and that I will not make any changes without discussing with the doctor first. If I use my medication at a faster rate than it is prescribed I understand that it will result in my being without medication for a period of time.**
_____ (initial and date)

* I understand this regimen will be reevaluated periodically and if there is no evidence that I am improving, or that progress is being made to improve my function or my quality of life, the regimen will be tapered to my previous regimen or I may be referred to a pain clinic. _____(initial and date)

*Doctor Knight and I agree that this agreement is essential to the Doctor's ability to treat the Patient's pain effectively, and that failure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This agreement is entered on this date _____.

_____Patient

_____Doctor

_____Witness

And I acknowledge that I'm keeping this signed copy

_____Patient

Appendix 1

MME Worksheet

Calculating Current MME Dose

Opioid (doses in mg/day except where noted)	Conversion Factor
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone (I refuse to prescribe this drug)	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

-Current Medication 1: _____

_____ X _____ = _____
Average Daily dose Conversion Factor MME Dose

-Current Medication 2: _____

_____ X _____ = _____
Average Daily dose Conversion Factor MME Dose

-Current Medication 3: _____

_____ X _____ = _____
Average Daily dose Conversion Factor MME Dose

I'm hoping I don't need that third line for anyone. But just in case.
Target Dose MME to be less than 120 MME:

Target Dose MME to be less than 60 MME (especially if take sedative-hypnotic):

THE CONTROLLED SUBSTANCE QUIZ

Because patients have told me that they really didn't read the agreement they signed, I have come up with a quiz you will need to pass as well. Don't worry we will discuss any wrong answers.

1) You filled 2 of your Vyvanse prescriptions (long acting Adderall), but you realized when you went to fill the third that it was past the 90 days the prescription is good for, so you can do which of the following:
   a) Call the office to ok the third prescription.
   b) Call the office to call in a new prescription.
   c) Call the office to make an appointment for new prescriptions.
   d) Call the office and ask to speak to nurse, she will surely understand and replace your prescription.
2) You left your hydrocodone (Norco) prescription in your hotel room when you were at a conference. You discovered that the maid must have taken half the pills. You should do the following next:
   a) Call the police.
   b) Call the hotel management.
   c) Call your doctor for replacement of the missing pills.
   d) Do nothing until you return home and then call the office.
   e) A or B is a good idea, but don't expect to get your pills replaced.
3) You are having surgery to replace a knee by Dr. Bones and already take extended release Morphine through our office. They have given you a prescription to take after surgery for Hydrocodone-Acetaminophen (Norco) 10mg/325mg, a quantity of 60. What do you do with this prescription?
   a) Take to the pharmacy to fill it to be ready for post-surgery pain.
   b) Refuse it because it violates your pain agreement.
   c) Call the office to report receiving it and to ask permission to fill it.
   d) Send it to your cousin in Iowa to fill so it doesn't show up on your record and have them send it back to you.
4) You believe you lost your Ritalin prescriptions when you moved. What can you do?
   a) Call the office to get new prescriptions called in
   b) Call the office to get new prescriptions to pick up
   c) Call the office to make an appointment for new prescriptions
   d) Call the office and ask to speak to nurse, she will surely understand and replace your prescription
5) You are planning a trip to New York and will be there for 3 weeks. Your prescription for oxycodone will be due to refill just a few days into the trip after you arrive. Which of the following are options that will likely work?
   a) You explain the situation to your doctor and get their ok to fill 3 days early.
   b) You explain the situation to your pharmacist and get their ok to fill 3 days early.
   c) You explain the situation to your pharmacist and they request a vacation waiver from your insurance company.
   d) You take your chances and take your written prescription to New York to fill there.
   e) Same scenario but substitute California.
   f) Same scenario but substitute Florida.
   g) All the above would likely work.
   h) None of the above would likely work.
6) Your insurance changes and you can no longer see Dr. Knight because she is not in your network. You get established with a new doctor, but they refuse to write your controlled substance prescription and refer you to psychiatrist (ADD) or pain doctor (Narcotic). Your options are as follows:
   a) See Dr. Knight and pay cash for visits.
   b) Call and ask Dr. Knight for 3 more months of prescriptions while you find a new doctor.
   c) Just quit your medications and hope for the best.
   d) Go to the ER and beg them to write for your medications.

7) If you are on a pain medication, then compute your daily MME and feel free to write on appendix 1. If you aren't on any pain medications, then pretend you take the following and do the same:
    i) Fentanyl patch 125 mcg/hr change every 3 days
    ii) Norco (hydrocodone 10 mg and acetaminophen 325 mg) 1-3 per day for break through pain
    iii) Ativan 1 mg twice a day for anxiety and sleep
8) The pretend patient in question #7 reveals they drink beer on weekends. What are they in danger of happening if they do that and take the medications as well?
9) Your friend, Larry, also takes the same controlled substance that you do and just so happens to also see Dr. Knight. Or so he says. He has run out of his hydrocodone (Norco) early and asks you if he can "borrow" a couple pills and will pay you back when he gets his prescription.
    a) You give him two but tell him it can only happen once and if anyone asks you will deny, deny, deny.
    b) You give him two but when he doesn't return 2, you call the office to report his "stealing" to us.
    c) You tell Larry, that it just isn't going to happen, no way, no how.
    d) You try to tell him that, but he's got throat cancer, so you give him 2 and say don't worry about it.

Yes, believe it or not these are all true scenarios (except one, I don't have a patient on pain pills named Larry) from 2018. Number 9, this is going to sound cruel, but you wouldn't believe how many people used to call me on the weekends and claim they saw a doctor in my call group and their husband has cancer but has ran out early or just moved back or some other sob story. Don't be a sucker. Cancer patients never call for drugs on weekends. Those are con artist, drug seekers, and why we have this system to protect you and us. Even if you KNOW they have cancer, don't do it. Apparently, a drug seeker unfortunately got cancer and is now using it to con you out of your meds.

10) You always call the office and see Dr. Knight in a GO appt and so you do that this week only to find out she's on vacation. You have which of the following options:
    a) She always leaves signed prescriptions for this very reason and one of the staff can get you a prescription to get you by until she is back.
    b) She warned you to make your appointments ahead of time because if they see that your appointment is going to fall during her vacation then they will move it up before she leaves.
    c) Go to the prompt care they will fill this one for you.
    d) Realize you screwed up and you can't do anything until she's back.
    e) Thank goodness, she hired a nurse practitioner that can write you a prescription.
11) You want to taper off your pain medications and that's why you got a cannabis card. When the card comes, you run to the dispensary and buy your first ever bag of the cannabis du jour. Next you should:
    a) Go low and go slow, meaning you must try a very small amount and wait a while before trying more to see how it will affect you. Don't change anything else.
    b) Start smoking a bowl a day and stop your opiates cold turkey.
    c) Start smoking a bowl a day and lower your opiate usage 10% every week.
    d) Make an appointment before you go to the dispensary to discuss how to start using cannabis with Ian, then make an appointment to see Dr. Knight to discuss how to taper off your pain meds 1-2 months after starting cannabis.
    e) A or D
    f) A, C, and D
    g) All the above
12) Please list your medications that are considered Scheduled Medications below and what level they are I, II, III, IV or V.

_____ _____ _____

_____ _____ _____

OK that's it folks. Try not to do anything in 2019 that makes me have to add questions to the quiz ok?