TITLE: CHRONICALLY PRESCRIBED CONTROLLED MEDICINES

CATEGORY: CLINICAL POLICY

NUMBER:

EFFECTIVE DATE: JULY 24, 2017

POLICY: Proper monitoring and prescribing methods to ensure both legal and clinical compliance with chronically prescribed controlled medications.

SCOPE: CHC patients sometimes need controlled medications on an ongoing, chronic basis for the maintenance of such problems as chronic pain, depression and anxiety and attention deficit disorder. Controlled medications are labeled as such due to the higher risk of dependency and abuse, and currently there is an epidemic of opioid and stimulant prescription drug abuse in our country and in our state. CHC providers and staff want to ensure effective symptom control while at the same time ensuring patient compliance and minimizing abuse and/or diversion. All patients age 13 years and older who are prescribed Schedule II controlled medications continuously or regularly recurring for a period of at least three months fall under authority of this policy. Patients prescribed controlled medicines of Schedule III-V in the same way may also fall under the authority of this policy, at the provider's discretion.

PROCEDURES:

1. **PRESCRIPTIONS:**
    a. All Schedule II medications must be prescribed with a printed (or written) and signed prescription (a physical prescription) and are valid for a period of 90 days.
    b. Schedule II medications are not eligible for refills.
    c. At the provider's discretion, and only with established, well-known and trusted patients, Schedule II prescriptions may be given in advance, for a maximum of 90 days. The future prescriptions must be printed with the statement, "Not to be filled before", followed by a valid date in the future. No such prescription will be valid after 90 days of the date written.
    d. Schedule III through V medications may be called in to a pharmacy or prescribed with a physical prescription and are valid for a period of 6 months.
    e. Schedule III through V medications are eligible for up to 5 monthly refills to a maximum prescription length of 6 months.
    f. The number of refills on applicable prescriptions is always at the discretion of the prescriber, and as allowed by law.
    g. No controlled medications may be faxed except in certain special situations, e.g. hospice care and residential facilities.

h. Controlled medications may be e-prescribed once the EHR is certified for such function (not until Allscripts TouchWorks version 15.1 as of the writing of this procedure).
i. The South Carolina Reporting & Identification Prescription Tracking System (SCRIPTS) will be checked for compliance initially and at least every three months for any patient on regular controlled medicines.
j. The day and the results of checking SCRIPTS website will be included in EHR either in the note for that day's visit, in a separate note specific to refilling the medication, or on the prescription itself. The notation must be easy to find for such reasons as a random audit.
k. No CHC provider will write a controlled medicine for themselves or for an immediate family member.
l. All controlled medicines will be recorded in the proper patient's chart in EHR, even if the situation exists where the prescription has to be hand-written.

2. **CONTROLLED MEDICINE CONTRACT:**
   a. Once a patient is determined to need chronic controlled medications, then a Controlled Medicine Contract needs to be printed, explained by either trained staff or the provider, and signed by patient or guardian, provider and witness.
   b. The patient is given a copy of the contract the day of signing.
   c. Annually, the contract should be reviewed and either the original be initialed and dated by the three individuals as above, or completely reproduced and signed by individuals as above.
   d. The patient should be seen at least every three months, or at least every 6 months in the situation of a pediatric patient on stimulant medicine for attention deficit diagnosis.
   e. Any violation of the contract may be cause for termination of the agreement, and patient might be deemed too high a risk for continuation of any or all controlled medications. The extent of the violation, the termination of the contract, and the cancellation of one or all controlled medications are all at the discretion of the provider.
   f. Examples of violations would be: illicit drug use, selling of prescribed drugs (evidenced by negative urine drug screens, abnormal pill counts, irrefutable external evidence, or by admission), obtaining same or similar controlled medications from other providers, or taking prescribed medication in an inappropriate or dangerous manner (such as taking too many too quickly in the month).
   g. Should diversion of the prescribed medication(s) be suspected, then unannounced pill counts may be requested of the patient. Incorrect counts or substituted pills may be interpreted as a violation of the Controlled Medicine Contract. Patients may be asked to bring medications to each visit, at the discretion of the provider.
   h. Failure to present for requested pill count may also be interpreted as a violation of the Controlled Medicine Contract.

3. **URINE DRUG SCREEN:**
    a. Once a patient is determined to need chronic controlled medications, then a baseline urine drug screen (UDS) will be obtained.
    b. UDS may be done randomly, at any time, with no patient warning, especially when there is suspect activity of the patient.
    c. After initial UDS (which is often negative if before therapy is actually started), then a repeat UDS should be obtained 1 to 3 months after the initial to ensure compliance with therapy.
    d. Once a patient is stable on treatment, and no suspect activity is occurring, then a UDS should be obtained approximately yearly to ensure compliance with therapy and to ensure no inappropriate activities.
    e. The patient should never be told before arrival on the day of the UDS when a test will be done.
    f. As of the writing of this procedure, the in-house "dipstick" portion of the test is inadequate to support therapy-changing decisions. Should the decision of stopping or starting medication need to be made based on UDS results, then the urine will need to be sent out for laboratory confirmation.
    g. Refusal to perform UDS should be considered equivalent to a positive (inappropriate) UDS.
    h. If the patient is unable to void after multiple attempts, a serum drugs of abuse panel may be collected at the discretion of the provider.
    i. Patient should be somewhat monitored (by discretion of staff) when giving urine specimen. High risk individuals may need direct observation during the entire procedure of giving the sample.
    j. A urine sample that does not register appropriate temperature, or is not filled to designated line, is not a valid sample.
    k. The giving of an invalid sample, for the purpose of passing the UDS, should be considered equivalent to a positive test.
    l. Adding any foreign substance to the sample (bleach, water, and other chemicals) should be considered equivalent to a positive test.
    m. Current dosing regimens and last dose taken should always be noted in the chart when a UDS is done.

4. **TERMINATION OF CONTROLLED MEDICINE CONTRACT**
    a. Termination of the Controlled Medicine Contract is not dismissal from the practice; the patient will be given the opportunity to continue seeing the provider, but typically no controlled medicines will be provided.
    b. Referral to a drug rehabilitation program will be offered.
    c. In significant breeches of trust and confidence, the provider-patient relationship may be broken to the extent that a dismissal is appropriate. In this such case, the standard request for dismissal procedure will be followed.
    d. Reinstating the Controlled Medicine Contract and resuming the prescription of controlled medicines is not appropriate for most patients, but the option is at the discretion of the provider. Recommended reinstatement procedure

would entail at least a three month waiting period and multiple appropriately-resulted confirmatory drug screens.

Review and revision history:
Created, reviewed and approved by medical staff April 11, 2017, changes made and final submitted to staff on July 24, 2017 with approval.
Minor revision with review and approval, February 13, 2018.