Adventist Health Clear Lake has adopted a pain management policy with your health in mind and in response to guidance from health experts and government agencies.

**Protecting Patients & Providers**

You may be aware of Centers of Disease Control (CDC) guidelines regarding the safety and efficacy of narcotics (also known as opioids) in treating non-cancer related chronic pain. Organizations including the Centers for Medicare and Medicaid Services (CMS), Partnership HealthPlan of California and the American Medical Association also have recommendations around prescribing opioids, a class of medications that includes morphine, oxycodone, Buprenorphine and hydrocodone.

Adventist Health Clear Lake’s policy, outlined below, complies with Drug Enforcement Agency guidelines and takes into consideration new research about how opioids are best used and how they affect the body over time. These guidelines are important for our providers to follow to maintain their medical license and ability to prescribe medications of all kinds.

By following these guidelines, we will continue to prioritize your long-term health and quality of life. Please let us know if you have any questions.

**OUR PAIN POLICY**

The information below outlines how our current pain policy affects patients currently prescribed opioids or those who may be prescribed opioids in the treatment of non-cancer related chronic pain.

**Avoiding high doses** — Providers will avoid prescribing doses over 50 morphine milligram equivalent (MME) per day.

**Tapering** — Providers will work with patients currently prescribed over 90 MME/day to taper according to our tapering guidelines. Please see the Tapering Information Sheet for more information about this process.

**No Soma prescriptions** — Carisoprodol, prescribed under the brand name Soma, is a muscle relaxant. Our providers will not prescribe Soma due to concerns about side effects and interactions with other medications.

**No “trinity” or “triad” combinations** — Providers will not prescribe opioids plus benzodiazepine (drugs such as Xanax, Klonopin, Valium and Ativan) plus muscle relaxants. This combination of drugs is shown to be a high risk combination and to cause overdose, which can be fatal.

**No dual prescriptions** — Providers will not offer patients two short-acting or long-acting opioid prescriptions at the same time (known as “dual prescriptions”).

**Urine drug screenings** — Urine drug screening for those prescribed opioids for chronic pain will be required every three months or more frequently.

**CURES reports** — A Controlled Substance Utilization Review and Evaluation System (CURES) report will be run every two months at minimum for patients prescribed opioids for non-cancer chronic pain. This report ensures that patients, pharmacies and providers are taking, dispensing and prescribing these drugs appropriately.

**Pain Management Contracts** — A Pain Management Contract signed by both the patient and provider will be required for any prescription for opioids for greater than 30 days.
Proposed Interim Policy for Opioid Prescribing in the Management of Chronic Noncancer Pain

- Avoid > 50 MME/d, generally
- All patients on > 90 MME/d must undergo mandatory tapering according to our tapering guidelines. If providers are unwilling to taper by 60 days after adoption of this policy, patients will be referred to pain management specialist
- Adopt Intermountain Healthcare tapering guidelines. *See attachment
- No Soma prescriptions
- No trinity/triad combinations (opioid plus benzodiazepine plus muscle relaxant)
- No dual short acting or long acting opioid prescriptions
- UDS required every three months at minimum
- CURES report every two months at minimum
- Signed pain management agreement prior to prescribing opioids for greater than 30 days
- Noncompliance with this policy in part or whole by 90 days may result in mandatory patient referral to pain management specialist for opioid management and removal of provider's privilege to prescribe schedule II prescriptions.

- All Chronic Non-Cancer Pain (CNCP) patients receiving an opioid prescription will be provided the prescription for 30 days or less and must be seen by their provider for a visitation at that time.
- Consider reducing UDS to minimum of every 4 months and CURES report to minimum of every 3 months.
Patient Pain Management Agreement and Consent

Patient Name: ___________________________ MRN: ___________________________

I WILL:

€ I will only get my pain medicine from this clinic during scheduled appointments.
€ I will take my pain medicine the way that my healthcare provider has prescribed it.
€ I will be honest with all my healthcare providers if I am using street drugs.
€ I will be honest about all the medicine I use. This includes medicine from stores and herbal medicines.
€ I will be honest about my full health history.
€ I will tell my healthcare provider if I go to an emergency room for any reason.
€ If I get pain medicine from an emergency room, I will tell my healthcare provider.
€ I will call this office if I am prescribed any new medicine.
€ I will call this office if I have a reaction to any medicine.
€ I will tell all other healthcare providers that I have a pain medication agreement.
€ I will tell the emergency room staff that I have a pain medication agreement.
€ I will take drug tests and other tests when I am told to do so.
€ I will go to office visits, physical therapy or counselling when I am told to do so.
€ I will follow directions for all treatment.
€ I will show up on time for all appointments.
€ I will make an appointment for refills before I run out of medicine.
€ I will tell my health provider if I will be out of town so that I can get my refills.
€ I will get past health records from other offices when needed.
€ I will deliver these records by hand if needed. I will do this within one month of being asked.
€ I will pay for these records if needed.
€ I will give permission to this clinic to talk about my treatment with pharmacies, doctors, nurses, and others who are helping me.
€ I will give permission to any healthcare provider to get information from this clinic about my health and my pain treatment.
€ I alone am responsible if I overdose on medication whether accidentally or on purpose.
€ I will tell my healthcare provider if I plan to become pregnant.
€ I will tell my healthcare provider if I am pregnant while I am taking pain medicine.
€ I keep my medications in a safe and secure place.
€ I will refrain from using alcohol or other medications that may interact with my medication.
€ I will report all side effects with my provider.
€ I will ask questions when I do not understand medications, side effects or any other part of treatment.
€ If asked, I will bring in my pills to be counted at any time.

I WILL NOT:

€ I will not share or sell, or trade any of my medicine.
€ I will not take old narcotics from previous prescriptions.
€ I will not pick up prescriptions for narcotics that were previously written.
€ I will not use family and friends prescription medications nor will I share my medication with others.
I know that I cannot call the office to have my medicine refilled over the phone.
I will not go to the emergency room or other doctors for more pain medicine or other drugs.
I know that when I drive a car, working at heights (such as on a ladder), working around water (such as swimming) or use machinery, I must be fully alert. Pain medicines can make me less alert without me being aware of any problems with being alert. When I am taking pain medicines it is not safe for me to drive a car, work at heights or use a machine.
I will not stand in high places or do anything to hurt others after I have taken pain medicine.
I will not leave my medicine where it can be stolen or where others can take it.
I will not leave my medicine where children can find it. These medications are often fatal to children.
If I suddenly stop my medication, I may have withdrawal symptoms that can be severe.

WHEN USING A PHARMACY, I WILL:
I will use the same pharmacy for all my medicines. This is the pharmacy that I have picked.
I will not ask for early refills or more pain medicine, even if I lose my medicine.
I will not take old narcotics from previous prescriptions.

I KNOW THAT:
Pain management may include other treatment. Pain is often treated by more than just medication.
I cannot take more or less meds than what is prescribed by my provider
I will comply with my provider’s recommendations for my medical care.
I agree to urine drug screen at any time. If I refuse a urine drug screen my medications may not be prescribed.
I understand self-adjustment in medications can be dangerous to others and me.
Pain medicine will not get rid of all of my pain. Pain medicine may be able to reduce my pain so that I can do more and have a better life.
Part of my treatment is to reduce my need for pain medicine.
If the pain medicines work, I will continue to use them. The pain medication will not be continued if it does not help.
My medicines will not be replaced if my medication is lost or gets wet.
If my medicine is stolen, I will file a police report. In some cases (but not all) the medication may be replaced.
Any of my healthcare providers can find out from the California Prescription Drug Monitoring Program about any other medicines I get from any other pharmacy in California. This is called a CURES report.
My healthcare provider may contact the drug enforcement agency, if I try to get other doctors to give me pain medicine.
Healthcare providers may contact the drug enforcement agency if I am not honest about how I take pain medicine.
My doctor and my clinic will help with any investigation if I am suspected of prescription drug abuse or illegal activity.
I may be sent somewhere else for drug abuse or addiction help if I need it.
Pain medicine can be addictive. If medication is taken properly it is not an addiction, but your body and mind are likely to get used to the medication and it may be difficult to stop its use.
Presence of unauthorized substances may prompt referral for assessment of addictive disorder.
Use too much pain medicine can be fatal and I could die.
If I mix medicines or drink alcohol with my medication, I could also end up with serious health problems. I could die.

Here are some things that could go wrong if I use too much medicine or mix medicines:

<table>
<thead>
<tr>
<th>Overdose</th>
<th>Addiction</th>
<th>Constipation</th>
<th>Vomiting</th>
<th>Sleepiness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slower Reflexes</td>
<td>Nausea</td>
<td>Difficulty with Urination</td>
<td>Confusion</td>
<td>Itching</td>
</tr>
<tr>
<td>Problems with Sex</td>
<td>Dry Mouth</td>
<td>Depression</td>
<td>Trouble Breathing</td>
<td>Death</td>
</tr>
</tbody>
</table>

CAUSE FOR DISMISSAL FROM THIS CLINIC

I know that the pain medicines may be stopped if I break any part of this agreement. Where allowed by law, I may be reported to law enforcement authorities or your insurance company (such as MediCal).

My signature below means that I have read and understand this agreement.

Patient Name:

Patient Signature:

Date:

Provider Name:

Provider Signature:
Chronic Non-Cancer Opioid Pain Management Informed Consent (Page 1/2)

Patient Name: ___________________________ MRN: ___________________________ DOB: ___________________________

This purpose of this document is to help clearly communicate between patients and healthcare providers the risks versus benefits of long-term (greater than thirty days duration) opioid therapy, clearly define treatment expectations, and resolve any questions or concerns patients may have before treatment initiation.

My provider is prescribing opioid pain medications for the following condition(s):

________________________________________

I have discussed the possible risks and benefits of taking opioid medications for my condition with my healthcare provider and have discussed the possibility of other treatments that do not use opioid medications, including:

________________________________________

Please review all of the information listed here and put your initials next to each item, only when you have reviewed it with your healthcare provider and understand and accept what each statement says.

Opioid medications are being prescribed to me because other treatments have not controlled my pain well enough. ___

These medications are to be used to decrease my pain but they will likely not take away my pain completely. ___

When I take these medications, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing, and possibly death. ___

Taking too much of my pain medication, or mixing my pain medications with drugs, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing and possibly die. ___

It is my responsibility to tell any healthcare provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do not give me any medicines that may interact dangerously with my pain medicines. ___

When I take these medications it may not be safe for me to drive a car, operate machinery, or take care of other people. ___

If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured. ___

When I take these medications regularly, I will likely become physically dependent on them, meaning that my body will become accustomed to taking the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them too quickly. ___

*Adapted from the American Academy of Pain Medicine http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3211
Chronic Non-Cancer Opioid Pain Management Informed Consent (Page 2/2)

Patient Name: ___________________________ MRN: ___________________ DOB: ____________________

I also may become psychologically addicted to these medications and require addiction treatment if I cannot control how I am using them, or if I continue to use them even though I am having bad or dangerous things happen because of the medications.

Anyone can develop an addiction to opioid pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past are at higher risk. I have told my provider if I or anyone in my family has had any of these types of problems.

Withdrawal symptoms feel like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

I understand that it may become medically necessary for me to be administered certain medications such as buprenorphine (Suboxone®, Subutex®, naltrexone (ReVia®), nalbuphine (Nubain®), pentazocine (Talwin®), or butorphanol (Stadol®), which will reverse the effects of my pain medicines and may cause me to experience withdrawal.

(For Men): Taking opioid pain medications chronically may cause low testosterone levels and affect sexual function.

(For Women): It is my responsibility to tell my provider immediately if I think I am pregnant or if I am thinking about getting pregnant. If I become pregnant while taking these medications and continue to take the medicines during the pregnancy, the baby will be physically dependent on opioids at the time of birth and may require withdrawal treatment.

These medications are to be used to help improve my ability to work, take care of myself and my family, and meet other goals that I have discussed with my provider, but if these medications do not help me meet those goals, they will be stopped.

I have reviewed this form with my healthcare provider and have had the chance to ask any questions.

I understand each of the statements written here, and by signing below, I give my consent for treatment of my pain condition with opioid medications.

Patient Name ___________________________ Patient Signature ________________ Today’s Date __________

Provider Name _________________________ Provider Signature ________________ Today’s Date __________

Witness Name __________________________ Witness Signature ________________ Today’s Date __________

*Adapted from the American Academy of Pain Medicine http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3211