Benzodiazepine Receptor Agonist Treatment Agreement

Patient name: _____

Date: _____

This **benzodiazepine receptor agonist** (BZRA) medication _____

is being used to manage or control symptoms of _____ .

My specific goals with this treatment are to

_____ .

I understand that the use of this medication can cause addiction and carries other risks such as drug interactions, sedation, confusion, poor memory, increased response time and impaired coordination which may increase the risk of motor vehicle accidents and falls. As I age, I may be especially sensitive to these side effects. In most situations, benzodiazepines are not recommended for use beyond four to six weeks. Benzodiazepines are not recommended for daily or long-term treatment of generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), or insomnia. Given the risks associated with this class of medications, my doctor may reduce or safely stop prescribing benzodiazepines to me at any time during my treatment based on how I respond to treatment and whether continued use could likely harm me.

While on BZRA medication, I agree to abide by the following conditions:

1. **Receive medications from a single prescriber.**

   Dr. _____ will be the only doctor who will prescribe the BZRA medication _____ for me. I will not seek to obtain BZRAs from any other prescriber. In case of a situation where I receive a BZRA from another prescriber, I will notify my doctor as soon as possible.

2. **Take the medication as prescribed.**

   I will take the medication at the dose and frequency ordered by my doctor. I will not increase the dose or frequency of my medication on my own. I agree to keep track of my use of these medications and how well they are working for me to share with my doctor at appointments, e.g. by maintaining a sleep diary.

3. **NOT consume other sedating medications or alcohol with this medication.**

   Use of BZRA with other medications that may cause drowsiness such as opioid pain relievers (including non-prescription codeine) or with alcohol can be serious and life threatening. Naloxone will not reverse the effects of BZRA overdose. I will not combine my medication with other drugs without consulting my doctor first nor will I combine my BZRA medication with alcohol.

4. **NOT abruptly stop my medication.**

   Discontinuing BZRA suddenly after extended use can cause potentially serious withdrawal symptoms. The likelihood of experiencing withdrawal can be reduced by tapering or gradually

reducing the dose. I will consult with my doctor before stopping my medication to discuss a tapering plan.

5. **Maintain regular appointment attendance and participating in consultations.**

   I understand that I need to be present at all appointments with my doctor. I must also be willing to fully participate in other treatments or consultations, such as psychotherapy, recommended by my doctor. Receiving medications from a single pharmacy. I will fill my prescriptions at a single pharmacy of my choice which will be _____. If I decide to move to a different pharmacy, I will notify my doctor.

6. **Store and dispose of the medication safely.**

   I will store my medications in a secure location at all times. I will not share or give my prescribed BZRA medication to another person, nor will I accept these medications from anyone else. If I have benzodiazepine medication remaining that I no longer need (e.g. in the case that my medication is discontinued or changed), I will take it to my pharmacy for safe disposal. I understand that I may not obtain an early refill or replacement supplies for lost medication.

7. **Addiction.**

   I am aware that there is a small but real risk that I may become addicted to the prescribed BZRA. The risk of addiction is increased with a past or present history of substance or alcohol use disorder, and prescribed BZRAs are often reported as a cause for relapse in recovering patients. A history of SUD does not preclude the use of BZRA but warrants increased pharmacovigilance. I know that my doctor may order a consultation with a specialist in addiction medicine if there is a concern about addiction.

8. **Adherence.** I understand that my doctor may ask me for a urine drug screen sample or a count of my pills at any time. This is performed routinely for all patients to improve the overall safety of using BZRA. Urine drug monitoring will also look for other substance use that increases the risks associated with using a BZRA. Further refills/prescriptions will be tied to completion of urine tests. Doctors and clinics are encouraged to consider a policy of random urines for all patients on a BZRA that are not designated palliative or cancer patients.

9. **Be responsible for medication supply and refilling on time.**

   I will manage my medication supply by planning and booking my appointments in advance. If I run out of medication early (e.g. by missing an appointment or taking more than prescribed), extra doses may not be prescribed in which case I will have to wait until my next prescription is due. I will bring my pill bottles with any remaining pills of the medication to each appointment.

10. **Comply with clinic adherence monitoring policies.**

    I understand that my doctor may ask me for a urine drug screening sample or a count of my pills at any time. These measures are performed for all patients to improve the safety of prescribing BZRA. Further refills/prescriptions will be tied to completion of requested screening.

11. **Consent to share information with other health care professionals if medically necessary**.

    I agree that my doctor has the authority to share information with other health professionals involved in my care if necessary. My pharmacy will be receiving a copy of this treatment agreement.

12. **Termination of this agreement.**

    If my doctor determines that the medication is causing me more harm than the relief it provides, my doctor has the right to discontinue my BZRA medication in a safe way. I also acknowledge that I could lose my right to treatment from my doctor if I break any part of this agreement.

13. **Specialist consultation.**

    I understand that my physician may require me to attend consultation with a psychiatrist or addiction medicine doctor to continue to safely prescribe the medication.

This document was discussed between me and my doctor. I was given the opportunity to ask questions. I affirm my understanding and acceptance of the terms of this agreement by signing this document.

THIS AGREEMENT MADE THE _____ DAY OF _____, 20_____.

_____ _____

Patient signature **Prescriber signature**

_____ _____

Patient name (printed) **Prescriber name (printed)**

Review dates

This agreement was revisited on this _____ day of _____, 20_____.

_____ _____

Patient signature Prescriber signature

This agreement was revisited on this _____ day of _____, 20_____.

_____ _____

Patient signature Prescriber signature

This agreement was revisited on this _____ day of _____, 20_____.

_____ _____

Patient signature Prescriber signature

This agreement was revisited on this _____ day of _____, 20_____.

_____ _____

Patient signature Prescriber signature