BENZODIAZEPINE MEDICATION MANAGEMENT AGREEMENT

Benzodiazepine medications can be a highly effective part of care. Due to the properties of the medication and current public health trends, use of benzodiazepines requires prioritization for clients and clinicians alike. The decision to use benzodiazepine medications was jointly made to reduce specific symptoms. I acknowledge and agree to the following conditions to make treatment as safe and successful as possible:

1. I am aware that the use of such medicine has certain risks associated with it. I have reviewed the benzodiazepine medication handout and have a safe plan for successful use. I agree to use and or develop good health habits: exercising, engaging in therapy and/or other primary recovery practices, and using moderation with caffeine and other foods that may increase anxiety and/or insomnia.
2. I understand that due to safety and effectiveness concerns, my benzodiazepine prescription will be used as a secondary medication (with SSRI or other classes of medication used primarily). I agree that this is a temporary prescription that will be discontinued once psychotherapy and a primary medication is established.
3. I am aware that other medications can interact with benzodiazepines and cause significant safety risks. I agree to tell my doctor about all other medicines and treatments that I am receiving. I will not request or accept controlled substances/medications from any other physician or individual without talking about it with my provider while I am receiving a benzodiazepine medication. In the event of hospitalization, I will inform hospital staff of my complete medication list and coordinate notice of any new or changes medications with my physicians prior to my hospital discharge.
4. I am aware that using alcohol and benzodiazepine medication is contraindicated. Benzodiazepine medication and alcohol work on the same receptors in the same parts of the brain. Using alcohol and benzodiazepine medication at the same time can lead to dangerous sedation (and in rare cases can be fatal).
   I will avoid abusing alcohol while taking benzodiazepine medication.
5. I understand the following refill policy will apply:
   - *Medications will not be refilled early, even if they have been lost, stolen or destroyed.*
   - *Medications will not be refilled on Fridays, weekends, or holidays.*
   - *Medications will not be refilled by other physicians or providers.*
6. I will keep all prescribing clinicians fully informed of any changes, ER visits, lost or stolen medications or any other circumstances affecting my health and well-being.
7. I agree to use one pharmacy for all my medications. Due to increased awareness concerning overdose and abuse, health care providers are cautious about benzodiazepine prescription misuse and abuse. To avoid misunderstanding, stigmatizing judgments, and to ensure safety, I agree to coordinate in advance any change in pharmacy and keep a current list of medications.
   This information may be verified by the Tennessee Prescription Database to ensure safety.
8. I agree to discuss medication use and communicate safety concerns during scheduled appointments.
9. I have been informed about the potential psychological dependence of this medicine. I know that some people develop tolerance, which is the need to increase the dose of the medication to achieve the desired effect. If using the medication longer than a few weeks, I may develop physically dependence that includes physiological and psychological responses when the medication is reduced or stopped. When, I stop the medication I must do so slowly and with medical supervision to manage withdrawal symptoms.
10. I agree that it will be discontinued if it is not used as directed, if I obtain controlled substances elsewhere (even from a physician), if I use illicit drugs, if I share controlled substances with others, or if I alter a prescription. Concerns for lack of safe use and misuse will be discussed directly and respectfully.

Both patient and prescribing physician have read this agreement, fully understand the decision to use benzodiazepine medication, and agree to the terms of this agreement.

Patient Printed Name:_____ Signature and date:_____(___/___/_____)

Name of Pharmacy to be used: _____

Provider: Lauren Hansen, DNP, WHNP-BC Signature and date:_____(___/___/_____)