Patient Name:_____Date:_____

Pain & Addiction Medicine Policy

It is important to realize that patient's have a vested interest in the success of treatment. They are not only participant but also care giver. A **Multidisciplinary Approach** necessitates providing a minimum standard of treatment modalities to address chronic patient's basic needs such as Physical Medicine, Interventional Medicine, and Behavioral Medicine. **These are the foundation stones upon which additional treatment modalities are laid.**

In addition, since there are many concerns regarding medicine diversion, abuse, and addiction, Multidisciplinary Pain & Addiction Medicine **necessitates a signed patient agreement for participation**. This is a contractual agreement between the patient and the practice that spells out what is expected from each party. **Patients should know that they will have medications prescribed and dosed at the discretion of the physician not their particular likes or dislikes**.

It is often helpful to engage a compounding pharmacy to make blinded elixirs or lozenges for pain management patients. We find it helpful to use morphine immediate release with an NSAID and hydroxyzine. **The patient may be told what medications are included in the elixir/lozenge but dosages are not divulged.** Of course the patient has the right to know the dosages but when divulged our treatment agreement is no longer in effect. When first treating a patient who is already on large doses narcotics for pain management, or those that have violated their agreement, it is the elixir/lozenge I turn to first. The elixir is prescribed on a return clinic visit, first weekly to adjust dosages, then biweekly, then monthly. Never should the patient be prescribed more than one month of medication at a time nor should medications be administered without a clinic visit. With this approach transition can be made using morphine equivalents, the patient cannot divert the medication (sales, snorting it, shooting it up), and the patients' dosage can be manipulated, without the patients' knowledge and behavioral responses, to fine tune the lowest dose of narcotic needed to control the patients pain. This approach also works well for patients detoxing.

Narcotic naïve patients should not initially be given narcotics (scheduled drugs like benzodiazepine, muscle relaxants like Soma, opiates, etc…). Some pain patients like those with Fibromyalgia, Interstitial Cystitis, Migraines, IBS, should probably never receive narcotics. Patients identified as needing opiates should be first started on opiates like Tramadol. If they need more then Tramadol ER then we may add an elixir or lozenge. If they need more than an elixir/lozenge then we may add a long acting narcotic like Morphine ER, Fentanyl Patch, or others. Methadone is a long standard but due to its implication with all cause mortality it is best avoided.

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It needs to be emphasized that narcotics, although a mainstay for pain management, should only be given when all other modalities are implemented. One of the purposes of a multidisciplinary pain management is to discourage diversion, minimize narcotic use, increase functionality, decrease progressive opiate tolerance, prevent iatrogenic addiction, and utilize narcotic need as a marker of disease progression or regression. In general; when a patient needs a "sleeper" then a non-addictive medication like an antihistamine is a better choice than an addictive one like zolpidem or a benzodiazepine, or when a patient needs a muscle relaxant then a non-addictive one like methocarbamol is a better choice than carisoprodol.

This Pain & Addiction Policy should be gone over in detail, understood and signed by the patient so there is no questions regarding violations that would necessitated termination of services; i.e. - doctor shopping which should be checked at each visit against a prescription **drug monitoring program like CURES** in California. No refills for any reason without a clinic visit. And **random urine drug screens** to check that the patient is taking what they have been prescribed and not taking anything else.

Violations shall be documented in the patients record and clinic visit time reduced. We use a **three strikes rule** whereby the patient is discharged from our services on the 3rd consecutive violation. Violators' clinic schedule is essentially in reverse of the pain medication schedule. That is; when a violation is found it is documented in the patients chart and the patient is required to return to the clinic at two week intervals, instead of monthly, for their evaluations and medication prescriptions. After two months, if there has not been another violation, the patient is returned to their monthly follow-up scheduling. If during their first violation a second violation is noted then the patient is required to have weekly follow-ups for medication prescriptions and evaluation. If during this time a third violation is noted the patient is discharged from service. If no violation is noted after 1 month then the patients' follow-up schedule is made biweekly and if still without violation the schedule is extended back to the original monthly visit. This approach may seem overly tough to some and lax to others. **It should be kept in mind that pure drug seekers will not tolerate such a program so patients that do participate are obviously seeking help.** Violations simply make apparent other problems (like hidden agendas, addiction, abuse, financial, psychosocial, etc…) that need to be addressed as part of the patients' treatment.

MD Health Clinics, Inc.

Patient acknowledges that this "Pain & Addiction Policy" has been read and understood.

Patient Signature: _____

Date: _____

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