CONTROLLED MEDICATION POLICY

Due to recent changes in government regulations regarding the dispensing of controlled medications, Cucamonga Valley Medical Group (CVMG) will now be instituting the following new rules whenever a controlled or "triplicate" prescription is generated by any provider in our offices.

Examples of such medications (but not limited to) include: Ultram (Tramadol), Vicodin/Norco (Hydrocodone), Percocet (Oxyco-done), Tylenol #3/#4 (Acetaminophen with Codeine), Xanax (Alprazo lam), Ativan (Lorazepam), Restoril (Temazepam), Ambien (Zolpidem), Soma (Carisoprodol), and all manner of prescription ADD/ADHD treatments.

- Controlled/scheduled medications must be filled in person with an office visit once a quarter (every 3 months).
- There will be no early refills of medications.
- No refills will be provided for lost or stolen medications.
- Labs need to be done at least annually in order to ensure that medications are not damaging the liver or kidney.
- Change in medication or dosage will likely require specialist evaluation (pain management, neurology, rheumatology, etc.).
- Medications will not be refilled if labs or consults are not completed.
- If these medications are filled by multiple providers or multiple pharmacies, it will be grounds for dismissal from CVMG.
- A urine drug screen is required to be done in the office at the time of your visit at least once a year, at the pro vider's discretion. Failure to comply or if illegal substances, including but not limited to substances illegal in the state of California or prescription medications which have not been prescribed directly to you, are found to be present in the urine screen, no refills will be provided.
- If you cannot comply with this policy, you may be asked to find another primary care physician.

My signature below indicates that I acknowledge this new regulation and formal policy regarding controlled medications and that I agree to comply.

_____   _____
PRINT NAME OF PATIENT   Date of birth:

_____   _____
SIGNATURE OF PATIENT (IF PATIENT IS A MINOR, SIGNATURE OF GUARDIAN)   DATE

_____   _____
SIGNATURE OF PROVIDER   DATE