

CERTIFICATION OF NEED FOR CONTROLLED SUBSTANCE USE

PARTICIPANT'S CERTIFICATION OF NEED FOR CONTROLLED SUBSTANCE USE

I, _____, hereby certify that I have a legitimate prescription for _____ (controlled substances or CS) and understand that whereas CS are usually avoided in individuals with a history of chemical dependency, that, in order to remain compliant with my DOPL or URAP Agreement, I certify to the following:

- A. The medical condition(s) for which I take CS is(are)

- B. I have exhausted all other reasonable alternative treatments and medications for this condition and have found these CS to be a necessary component of treatment which provides satisfactory relief of symptoms of the above condition.
- C. I am taking the these CS exactly as prescribed by my prescriber, who is

- D. I am obtaining my prescription for these CS from only a single prescriber, above named, and am filling the prescription at only a single pharmacy, which is

- E. I will submit a copy of every prescription or refill of each CS that I receive to URAP or DOPL just as I am currently required to do with all mood-altering or controlled substance prescriptions.

Signature: _____ Signature Date: ___/___/___

(This section to be completed by the Prescriber)

PRESCRIBER'S CERTIFICATION OF NEED FOR CONTROLLED SUBSTANCE USE

I hereby certify that I, *(name and degree)* _____ am the prescriber of _____ which are controlled substances (CS) to the above named patient who has informed me they suffer from the disease of chemical dependency and further verify, to the best of my understanding, the following facts:

- A. The medical condition(s) being treated is(are)

- B. All other reasonable or usual therapies used to treat this condition have been exhausted and have not produced the degree of success that the inclusion of these CS in the regimen has accomplished.
- C. This patient is not receiving prescriptions for these CS from anyone other than myself or my partners or associates and is filling such prescriptions at only one pharmacy as listed above.
- D. The patient is taking these CS exactly as prescribed by me and has not asked for early refills, unusual quantities or increasing amounts.

Prescriber's Signature: _____ Signature Date: ___/___/___