Gilbert Center
For Family Medicine

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NOTICE TO PATIENTS

CONTROLLED SUBSTANCE & NARCOTIC PRESCRIBING POLICY

Gilbert Center for Family Medicine has a **NO CHRONIC NARCOTICS / NO CHRONIC CONTROLLED SUBSTANCE** policy for **new patients**. We will not prescribe long-term or chronic narcotics, opioids, benzodiazepines, stimulants, sedative-hypnotics, or other controlled substances to new patients at the initial visit. This policy is consistent with **Arizona Revised Statutes §32-3248 and §32-3248.01**, the Arizona State Board of Pharmacy Controlled Substance Prescribing Monitor Program (CSPMP), and CDC Clinical Practice Guidelines for Prescribing Opioids (2022).

Controlled Substances Covered by This Policy (DEA Schedules II – IV):

Schedule II — Opioids / Narcotics	Schedule II — Stimulants	Schedule III / IV — Sedatives, Benzos & Other
Fentanyl (Duragesic, Actiq) Hydrocodone (Norco, Vicodin) Oxycodone (OxyContin, Percocet) Oxymorphone (Opana) Hydromorphone (Dilaudid) Morphine (MS Contin) Methadone Meperidine (Demerol) Codeine (high-dose)	Amphetamine/dextroamphetamine (Adderall, Dexedrine) Methylphenidate (Ritalin, Concerta) Lisdexamfetamine (Vyvanse) Methamphetamine (Desoxyn) Mixed amphetamine salts	Alprazolam/Xanax (Sch. IV) Clonazepam/Klonopin (Sch. IV) Diazepam/Valium (Sch. IV) Lorazepam/Ativan (Sch. IV) Temazepam/Restoril (Sch. IV) Zolpidem/Ambien (Sch. IV) Carisoprodol/Soma (Sch. IV) Tramadol/Conzip (Sch. IV) Butalbital compounds (Sch. III) Ketamine (Sch. III) Testosterone (Sch. III)

This list is not exhaustive. All DEA Schedule II–IV controlled substances are subject to this policy. Prescriptions are subject to mandatory CSPMP review per A.R.S. §36-2606.

EMOTIONAL SUPPORT ANIMAL (ESA) LETTERS

Gilbert Center for Family Medicine does **NOT** write letters for Emotional Support Animals (ESAs). Patients requesting an ESA letter will be referred to a psychiatrist or psychologist for evaluation. This is consistent with guidance from the American Academy of Family Physicians (AAFP) regarding scope-appropriate referral for mental health assessments.

I acknowledge that I have read and understand the above policies.

Patient Full Name (printed) _____ Date of Birth _____

Patient/ Legal Guardian Signature _____ Date _____

Relationship to Patient/ Representative's Authority (e.g. Power of Attorney, Guardian) _____