Checklist for Prescribing Benzodiazepines

Use Beyond 6 Weeks Not Recommend for Most Patients

Before Initiating BZD Therapy:

- ☐ Check that non-benzodiazepine alternatives tried and optimized
- ☐ Ensure patient is only receiving sedative meds from a single provider (close coordination between two providers also acceptable)
- ☐ Counsel patient on risks. (sedation, dependence, etc.)
- ☐ Discuss taper strategies
- ☐ Review PMP if new prescription >4 days
- ☐ Consider treatment contracts/ periodic urine toxicology testing
- ☐ Verify patient has no contraindications

Management of Patients on Chronic BZD Therapy:

- ☐ Check that non-benzodiazepine alternatives tried and optimized
- ☐ If suspected BZD induced disorder, first evaluate for primary behavioral diagnosis
- ☐ Assess effectiveness of therapy on ADLs and symptoms
  - Discontinue therapy if not improving ADLs
- ☐ Evaluate risk of harm or misuse

Patients 65+:

- ☐ Assess fall risk, drug interactions, risk of permanent cognitive impairment
- ☐ Use half of normal doses
- ☐ If abnormal LFTs use: Lorazepam, Oxazepam, Temazepam

Behavioral disorders:

- ☐ Ensure patients disorder is compatible with BZD therapy: Panic Disorder, Generalized Anxiety Disorder, Social Anxiety Disorder, Insomnia
- ☐ Check that non-benzodiazepine alternatives tried and optimized
- ☐ Consider co-prescribing with non-BZD during titration period for immediate relief
- ☐ Discontinue after 2-4 weeks

Patients receiving methadone/buprenorphine for opioid use disorder:

- ☐ Educate patient on risks
- ☐ Ensure close communication with treatment program
- ☐ Make effort to decrease/ replace BZD with alternative treatments
- ☐ Develop safety plan
- ☐ Check PMP regularly and address misuse if evident

Discontinuation of BZD Therapy

- ☐ Educate and share a clear plan for the future
- ☐ Provide replacement treatment if primary behavioral health diagnosis identified
- ☐ Initiate taper if needed
- ☐ Consider concurrent supportive psychotherapy during taper process
- ☐ Offer “rescue” dose: one dose to use at their discretion
  - Provides reassurance and sense of control
- ☐ For higher potency/ short acting BZD’s consider slower taper
  - May also switch to lower potency/ longer acting BZD and then taper to attenuate withdrawal symptoms and allow for longer taper with smaller doses
- ☐ Also consider taper strategy for discontinuation of “Z” drugs

NON-BZD ALTERNATIVES

- Antidepressants (SSRIs, SNRIs, TCAs)
- Psychotherapy (CBT)
- Serotonergic agents for anxiety (Buspirone)
- Restless Leg Syndrome (Pramipexole, Ropinirole, Gabapentin)

CONTRAINDICATIONS

- Active/ history of substance abuse (Opioid Use Disorder)
- Pregnancy/ risk of pregnancy
- Treatment with opioids for chronic pain
- Medical/ mental health problems that may be aggravated by BZD therapy (Borderline Personality Disorder)
- Cardiopulmonary disorders: Asthma, Sleep Apnea, COPD, CHF (BZD may worsen hypoxia/ hypoventilation)

EVALUATING RISK OF HARM OR MISUSE:

Risk Factors:

- Not taking medication as prescribed
- Concurrent use with illicit drugs/ alcohol
- Drug-drug interactions
- Cognitive impairment
- Recent Falls

TAPER STRATEGIES

- 25% every 2-3 weeks
- 12.5% for the last 2 weeks if needed
- For high potency/ short acting: as slow as 0.25mg of TDD per week