

Berkeley Pediatrics Controlled Substance Medication Policy

Stimulant medications are controlled substances that are regulated by the DEA and require a special controlled electronic prescription. Refills for this type of medication should be requested at least 5 business days before the medication is needed.

In order to ensure there are no delays in filling your (child's) prescription, please ensure your child has been accessing care appropriately. In addition to the regular annual exam patients who receive these medications have additional medication check visits (every 3-6 months once the dose is stable and more frequently while a dose is being adjusted).

Prescriptions will be refilled electronically. Please see refill instructions below. We will do our best to have refills sent within 5 business days of the request.

- To request your child's refill please use MYCHART. You can send a medication refill request or send a MyChart message including the following information:
 - MEDICATION NAME, STRENGTH & DOSE (e.g. methylphenidate 5 mg tablets- 2 tablets twice a day)
 - Patient's name and date of birth
 - Phone number to reach you if questions arise
 - Parent's name
 - Quantity of pills requested
 - Preferred pharmacy

Please note:

- We do not fill these prescriptions over the weekends or on holidays.
- Medications will only be refilled by the Primary Care MD, not by the on-call provider (except in the case of a prolonged absence of your doctor).
- These medications have a high potential for abuse. The medication should always be kept in a locked area, away from young children and teens. This medication must never be shared with others. Sharing or selling your ADHD medication is illegal.
- We are limited to prescribing no more than 30 days at a time.

Again, please note, prescriptions will not be refilled unless your child has had a well check examination in the last 12 months AND any recommended additional ADHD medication follow up visits.

Keeping track of when prescriptions will be needed is critical to avoid a gap in medication. Thank you for your understanding regarding the controlled substance prescription policy.

I understand and agree to abide by the Berkeley Pediatrics controlled substance prescription policy.

Patient's Name

Birth Date

Print Name of Parent

Signature of parent/guardian (or patient if <18 yrs)

Date