# SUICIDE PREVENTION STRATEGIC PLAN

## 2027

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

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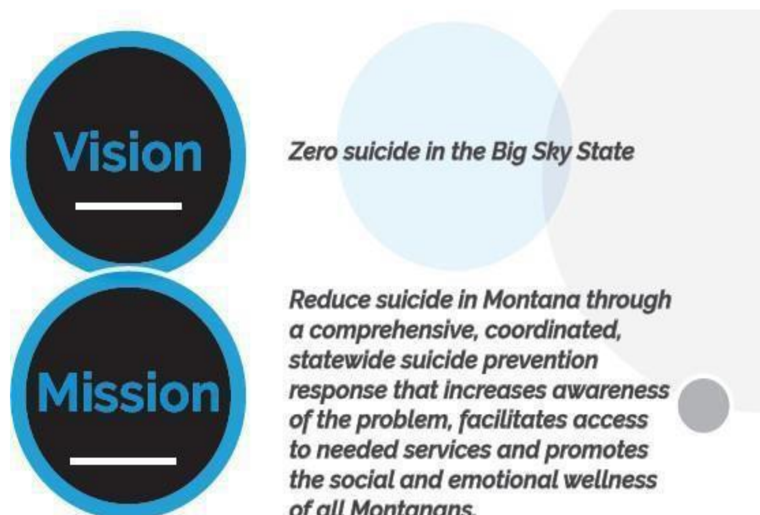
# OVERVIEW

This 2027 suicide prevention strategic plan includes goals, objectives, and strategies designed to support a multifaceted, coordinated approach to reducing suicide in our state. It includes tracking progress on the strategic activities of each of the five goals. Additionally, information on suicides among the armed forces and current Montana initiatives aimed at reducing suicides among our veteran population, is discussed, as well as the exploration of controlled substance information in deaths ruled to be a suicide. This plan and its priorities are updated biennially.

As part of a continued effort to build a strong suicide prevention infrastructure, the Department of Public Health and Human Services (DPHHS) participates in statewide meetings with key stakeholders and partners on a yearly basis.

## ALIGNMENT WITH DPHHS STRATEGIC GOALS

The following plan outlines key strategies to reduce the suicide rate in Montana and aligns with DPHHS's 2019- 2024 strategic plan to improve and protect the health, well-being, and self-reliance of all Montanans. The Suicide Prevention Strategic Plan correlates directly to DPHHS's goals to promote health equity and improve population health; strengthen the economic and social well-being of Montanans across the lifespan; ensure all children and youth achieve their highest potential; effectively engage stakeholders; and ensure core business services are efficient, innovative, and transparent. The following plan aligns also with the 2024 National Strategy for Suicide Prevention (U.S. Department of Health and Human Services (HHS), National Strategy for Suicide Prevention. Washington, DC: HHS, April 2024).



# GOALS, OBJECTIVES, AND STRATEGIES

## GOAL 1

Implement a suicide prevention program led by the suicide prevention office based upon the best available evidence.

**Objective 1.1**
Dedicate core staff positions to carry out essential functions of DPHHS's suicide prevention efforts.

**Strategies**

1.1.1 Sustain a statutory suicide prevention coordinator and suicide prevention manager for the DPHHS Suicide Prevention Program.

1.1.2 Support and partner with the Director of American Indian Health to provide resources to tribal nations that reflect a cultural understanding and responsiveness.

**Objective 1.2**
Implement biennial suicide prevention action plan.

**Strategies**

1.2.1 The DPHHS suicide prevention office will continue to implement and update the state strategic suicide prevention action plan at a minimum of every two years, as required by statute.

1.2.2 A statewide stakeholder group will be updated on the progress of the Montana Suicide Prevention Strategic plan at the yearly stakeholder meeting. The DPHHS suicide prevention office will provide regular updates and consultation as needed to internal DPHHS staff.

**Objective 1.3**
Coordinate and integrate DPHHS's suicide prevention activities through the Suicide Prevention Program, encouraging cross-department collaboration and integration of programs across funding sources within state government.

**Strategies**

1.3.1 Improve communication and coordination across non-profit organizations and state branches, divisions, and programs to better collaborate on suicide prevention efforts through annual stakeholder meetings initiated by the

suicide prevention coordinator to provide for coordination of all suicide prevention efforts.

1.3.2 Policy and educational documents (i.e. website, postvention plan, state plan etc.) will be shared across these branches, divisions, and programs.

1.3.3 Continue to improve communication and coordination for crisis services through the 988 stakeholders' coalition.

1.3.4 Continue to improve communication and coordination for service members, veterans and their families through the Montana Warrior's Forward (Formerly the Governor's Challenge to prevent Veteran Suicide) stakeholder coalition.

**Objective 1.4**
Provide recommendations for changed or amended policies to DPHHS-based or published data, best practices, and state-specific data analysis.

**Strategies**

1.4.1 Maintain a link between the DPHHS suicide prevention coordinator and national experts in the field of suicidology to ensure a comprehensive approach to evidence-based practices and metrics. This will be achieved through consultation with the National Council for Mental Wellbeing, the American Foundation for Suicide Prevention, the American Association of Suicidology, the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Veteran's Administration's data experts, and other regional and federal entities.

## GOAL 2

Develop a comprehensive communication plan for suicide prevention.

**Objective 2.1**
Research effective suicide prevention messaging and explore resources to create and then disseminate public awareness messaging.

**Strategies**

2.1.1 Identify key internal and external stakeholder groups and a plan for outreach with targeted messaging strategies, including the 988 Stakeholder's Coalition and Montana Warriors Forward initiative (formerly the Governor's Challenge to prevent Veteran Suicide).

2.1.2 Promotion of 988 and suicide awareness in aging adult programs with emphasis on 211 to address social determinants of health specific to aging adults and other high-risk populations.

2.1.3 Explore use of existing public-facing platforms, including social media, to disseminate suicide prevention messaging and resources.

2.1.4 Continue to expand the current Montana 988 project communication effort to additional partners, including veterans' organizations, colleges, high schools, disability services, aging services, tribal communities and urban Indian health.

2.1.5 Continue to expand the current public information campaign for 988 for American Indian/Alaska Native (AI/AN) communities to additional tribal communities and urban Indian health centers.

**Objective 2.2**

Direct resources towards identifying and implementing evidence-based strategies to reduce access to lethal means through messaging for target groups.

**Strategies**

2.2.1 Work with substance abuse prevention experts to continue to promote safe storage and disposal of prescription medications.

2.2.2 Disseminate best practices from local county "Safer Communities Montana" and peer-established safe storage programs (i.e. Safe Place at the Southwestern Montana Veteran Food Pantry in Deer Lodge).

2.2.3 Support and promote initiatives around safe firearm storage and pharmaceutical disposal program through statewide media campaigns and training.

2.2.4 Through a memorandum of understanding between the Montana Veteran Affairs Division and the Department of Public Health and Human Services, a safe storage initiative will be implemented through Safer Communities Montana to complete three objectives:

1) Establish safe storage sites across Montana and connect them with 211 and 988.
2) Conduct safe storage training, in accordance with best practices.
3) Promote safe storage through media and engagement with stakeholders.

2.2.5 Continue to partner with subject matter experts and community stakeholders, such as the Veterans' Affairs (VA) and the Indian Health Service (IHS), to hold focus groups and study how to message best practice strategies, including reducing access to lethal means for high-risk individuals experiencing acute suicidality and/or mental health crisis.

## GOAL 3

Identify and use available resources needed to guide state, tribal, county, and local efforts, including crisis response efforts, in suicide prevention and intervention.

**Objective 3.1**
Oversee an overall suicide prevention training plan for prevention and intervention training within communities.

**Strategies**

3.1.1 Monitor the updated online toolkit resource with self-guided online educational resources for providers, residents, and different target populations.

3.1.2 Deliver a coordinated state-provided train-the-trainer program.

3.1.3 Maintain a database of trainers who have been trained in Question, Persuade, Refer (QPR) or suicide safe care for health care settings to use in spreading these trainings statewide.

3.1.4 Support Montana's university system in embedding suicide safe care training and principles into all curriculums for physical and behavioral health providers with internal capacity within the faculty to continue training.

3.1.5 Engage health care, behavioral health, and public health providers in planning for and delivering targeted training for suicide safe care. Specific high-risk populations include AI/AN, pediatrics, people with physical disabilities, and geriatrics.

3.1.6 Increase military cultural competency in primary care providers and identification of veterans seeking health care through continued participation in the Montana Warriors Forward initiative (formerly the Governor's Challenge to Prevent Veteran Suicide.)

**Objective 3.2**
Strengthening the crisis response system infrastructure in Montana through active partnerships with providers, funders, and community stakeholders.

**Strategies**

3.2.1 Maintain and strengthen the suicide crisis response infrastructure in Montana through support of the three-suicide prevention/mental health crisis lifeline call centers (988).

3.2.2 Coordinate with other Behavioral Health and Developmental Disabilities Division (BHDD) sections to enable an "Air Traffic Control" level of crisis management based on the "Crisis Now" model developed by the National Action Alliance for Suicide Prevention (NAASP) and the National Association of State Mental Health Program Directors (NASMHPD).

3.2.3 Support the use of Mental Health First Aid, Crisis Intervention Training, and other evidence-supported crisis interventions for law enforcement, first responders, and hospital emergency room staff.

3.2.4 Engage AI/AN representation in planning for crisis response system supports, including 988, for both urban and reservation-based Indian health centers.

3.2.5 Partner with community crisis service providers (Mobile Crisis Teams (MCTs), 911 Public Safety Answering Points (PSAPs), crisis stabilization facilities) to encourage the development of integrated crisis behavioral health care systems.

## Goal 4

Build a multifaceted, lifespan approach to suicide prevention.

**Objective 4.1**

Support efforts to ensure a systematic approach to provide suicide safe care by partnering with health care and behavioral health programs.

**Strategies**

4.1.1 Partner with organizations and initiatives that encourage the development of integrated behavioral health care models across Montana, creating "no wrong door" access to individuals with behavioral health concerns, including IHS and tribal health providers, pediatrics, and aging adults.

4.1.2 Support the use of universal depression and anxiety screening, substance use disorder (SUD) screening, suicide risk assessment, safety planning, lethal means counseling and follow-up contact within the health care community, including pediatrics, people with physical disabilities, and aging adults.

4.1.3 Support the use of suicide safe care with school counselors, first responders, behavioral health providers, and human resource personnel.

4.1.4 Support the use of universal depression and anxiety screening, SUD screening, suicide risk assessment, safety planning, lethal means counseling, and follow-up contact within urban Indian health centers and tribal health departments.

**Objective 4.2**

Develop a network of trainers to ensure a systematic approach to provide suicide safe care to health care and behavioral health programs.

**Strategies**

4.2.1 Provide suicide safe care training to health professionals through a network of trainers that has been developed and track the number of trainings completed.

**Objective 4.3**

Develop and support suicide prevention programs to address suicide prevention with at-risk groups in Montana.

**Strategies**

4.3.1 Develop and support suicide prevention programs for AI through the development of a local advisory council on each reservation and in each urban Indian health center. Theses local councils will provide representation to a state-level advisory council that will provide guidance to DPHHS on suicide prevention policies and practices for tribal groups.

4.3.2 Promote the use of the PAX Good Behavior Game in all elementary schools through school-based training and referrals to the University of Montana Health Center for Children, Families, and Workforce Development.

4.3.3 Promote the use of Youth Aware of Mental Illness (YAM), and Signs of Suicide (SOS) in secondary education.

4.3.4 Through the Montana Warriors Forward initiative, develop and support suicide prevention programs for Service Members, Veterans Suicide Intervention Officer (SIO), and Military Families by partnering with veteran services organizations, Montana National Guard and Reserve, and the Department of Veterans' Affairs (VA).

4.3.5 Collaborate with the Department of Labor to train employees in suicide awareness through "SafetyFestMT" conferences, providing resources to human resource directors, and training for companies and corporations.

4.3.6 Develop and support suicide prevention programs for individuals in the LGBTQ community through the development of culturally responsive publicity materials through the Montana 988 project and promotion of the Trevor Project.

4.3.7 Increase gatekeeper training with a focus on aging adults and to include utilizing the Columbia Suicide Severity Rating Scale, for first responders, senior care givers, senior centers, and faith-based leaders.

4.3.8 Increase gatekeeper training with a focus on those in the construction/building industry and to include utilizing the Columbia Suicide Severity Rating Scale.

4.3.9 Increase gatekeeper training with a focus on educators to meet legislative mandates requiring one hour of suicide prevention training every three years.

**Objective 4.4**

Establish policies, model practices, and develop resources in preparation for post-suicide response (postvention), including the event of a suicide cluster.

**Strategies**

4.4.1 Promote the online suicide postvention toolkit for communities across Montana through meeting with key stakeholder groups and community training.

4.4.2 Review existing crisis response infrastructure and models in communities to leverage and develop response teams for postvention (e.g., school crisis response model, Fetal, Infant, Child, Maternal Morbidity Review (FICMMR) teams, and regional emergency preparedness programs).

4.4.3 Promote the 988 tribal call centers as the hub of prevention and postvention efforts in Indian country using example models that have emerged in tribal communities.

4.4.4 Coordinate with Montana National Guard and Reserve headquarters, veteran service organizations, the Veteran Affairs (VA), and other agencies and peer networks aimed at reducing veteran and service member suicide to ensure that their suicide prevention standard operating procedures include postvention plans of action.

4.4.5 Through collaboration with the Office of Public Instruction (OPI) and community training, promote the use of the Montana Crisis Action School Toolkit on Suicide (CAST-S) in all Montana schools to reduce the risk of suicide contagion.

**Objective 4.5**

Maintain a statewide suicide prevention task force and receive feedback on actions taken to date and on improvements to the state strategic suicide prevention plan.

**Strategies**

4.5.1 Convene task force annually to review progress and receive feedback on action plan and assess strategic plan.

## GOAL 5

Support high-quality, privacy-protected suicide morbidity and mortality data collection and analysis.

**Objective 5.1**

Increase the use of data to understand the problem of suicide and effectively target interventions.

**Strategies**

5.1.1 Improve surveillance of suicide mortality data and suicide risk factors through the Montana Violent Death Reporting System (MT-VDRS) with funding from the Centers for Disease Control and Prevention (CDC).

5.1.2 Analyze existing population-level data to ascertain specific risk factors for suicide to better target evidence-based practices for suicide prevention.

**Objective 5.2**
Establish a system for using and communicating data.

**Strategies**

5.2.1 DPHHS Office of Epidemiology and Scientific Support (OESS) will compile an annual data report on suicide morbidity and mortality in Montana based on data sets available from MT-VDRS and identify recommendations.

5.2.2 DPHHS will provide suicide-specific grief resources to next of kin identified on all death certificates ruled a suicide.

# MONTANA SUICIDES BY THOSE WHO SERVED IN THE ARMED FORCES – 2024-2025

Source: Montana Violent Death Reporting System

Over the past two years, there have been 121 suicides by those who served in the armed forces. Below are demographics associated with those deaths.

- 72% of the suicides were aged 50 or older
- 97% were male
- 93% were white
- 69% did not have a college degree.
- 66% were either single, divorced, or widowed
- 76% died by firearm
- 21% worked in the construction or building industry
- 55% were not Montana natives (not born in Montana)
- 6% were not residents of Montana.
- Flathead and Missoula County had the highest percentage of armed forces suicides (12%).

## RISK AND PROTECTIVE FACTORS:

**Risk factors for suicide include:**

- Prolonged family separation during deployments.
- A “suck-it-up” culture with regards to mental illness. Although progress has been made, the perception remains that seeking treatment will jeopardize your career.
- A high-stress, zero-defect culture where a failure to meet standards results in significant pressure and harassment by peers and leaders.

- Non-judicial punishment under the Uniform Code of Military Justice, which often results in immediate reduction in rank and forfeiture of pay, causing extreme financial stress.
- An acquired and highly developed capacity for the use of firearms as a lethal means.
- Significant stress upon retirement or voluntary/involuntary separation from the service. Unlike many other careers, military service provides a well-defined and high-status identity. Losing it can be extremely traumatic.
- Female combat veterans are at much higher risk of suicide where a firearm is the lethal means due to much greater acquired capacity than their civilian counterpart.
- Military spouses are a greater risk due to social isolation during deployments and abrupt shifts in professional and parenting responsibilities.
- Military children are at greater risk due to the prolonged absence of one of their parents during deployments and frequent changes in schools and social groups.

**Protective factors for suicide include:**

- Unit cohesion: Soldiers who feel like an integral part of their team are less likely to suffer from perceived burdensomeness and social isolation.
- Command climate: When commanders and senior non-commissioned officers are engaged and broadcast their support for soldiers in need of mental health treatment, risk is greatly reduced. When command teams put families first and make sure spouses and children are not forgotten during deployments, risk is reduced.
- Training: Suicide intervention training like Applied Suicide Intervention Skills Training (ASIST) and the Army's Ask, Care, Escort-Suicide Intervention (ACE-SI) are very effective in instilling a suicide prevention (SP)/suicide intervention (SI) attitude in units. Soldiers react extremely well to being given the tools to intervene and to create a climate of openness and empathy in their unit. The Department of War resiliency training helps service members develop coping strategies and protective factors based on cognitive behavioral therapy skills.
- Postvention: There is a need for improved suicide postvention resources. When a suicide occurs within a unit, the loss is deeply felt because every member plays an important role in the team's strength and cohesion. With the right support and guidance, leaders can help their teams navigate the aftermath with resilience and care, reducing the risk of additional harm and fostering a path toward healing.
- Pre-, during-, and post-deployment mental health treatment: Availability of consistent and high-quality physical and behavioral health care.

## CURRENT MONTANA INITIATIVES AIMED AT REDUCING SUICIDES AMONG OUR VETERAN POPULATION

**Suicide Prevention Program Manager (Crisis/Veteran focus)**

The Suicide Prevention Program Manager (SPPM) focuses on the 988/Veterans Crisis Line implementation for Montana; the Montana Warriors Forward initiative and works collaboratively with Montana VA and Montana National Guard on suicide prevention initiatives for those serving in the Armed Forces.  The SPPM is a retired Veteran who previously served as the Suicide Prevention Coordinator for the Montana National Guard.

**Montana Warriors Forward (Formerly the Governor's Challenge to Prevent Veteran Suicides)**

**Montana Warriors Forward Mission**

- **Task** – Implement a suicide prevention program for Montana's Service Members, Veterans and their Families (SMVF) that addresses the root causes of suicide through identification and screening for risk, building protective factors and facilitating care transitions for those determined to be at risk and by providing safe storage and/or disposal of lethal means for individuals in crisis.
- **Purpose** – To reduce the number of suicides among the SMVF community in Montana and to build a network of protective factors to reduce suicide risk.
- **End state** – The suicide rate for SMVF in Montana lowered to below the state rate and a statewide network of providers and protectors established to keep it that way.

### Goals of the Montana Warriors Forward Stakeholder's Coalition

BUILD A COALITION OF INDIVIDUALS AND AGENCIES INVOLVED IN SUPPORTING SMVF IN THEIR COMMUNITIES.

SOLICIT IDEAS FOR EXPANDING THE PROGRAM'S REACH AND IMPACT.

ASSIST PEER COACHES WITH BUILDING SMVF SUPPORT UNITS IN UNDERSERVED COUNTIES AND TRIBAL COMMUNITIES.

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### Montana Warrior Forward Priority Areas

**Priority Area 1**

*Identifying SMVF and Screening for Suicide Risk*

**Priority Area 2**

*Promoting Connectedness and Improving Care Transitions*

**Priority Area 3**

*Increasing Lethal Means Safety and Safety Planning*

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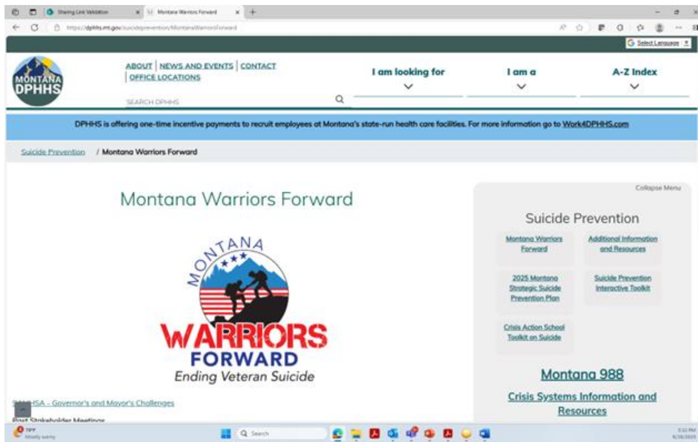
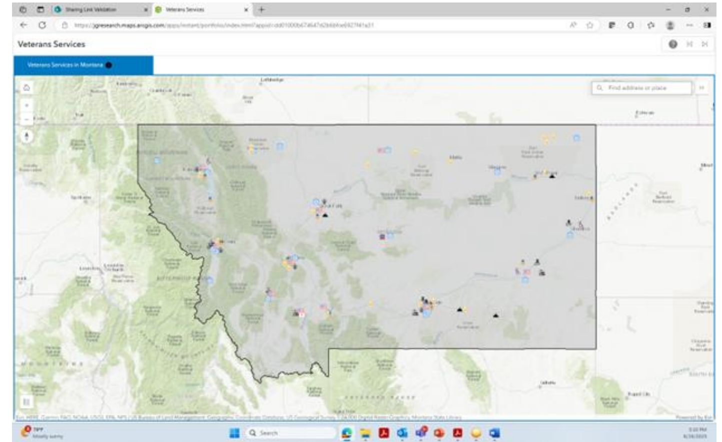
### Montana Safe Storage Initiative

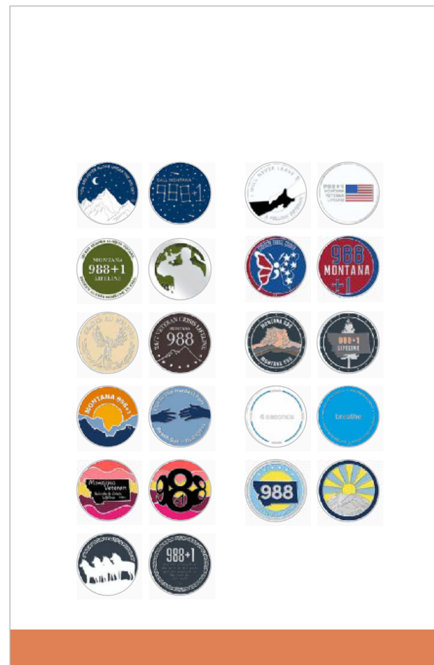
- $300,000 for the biennium was allocated to Montana Veteran Affairs Division (MVAD) for the safe storage of lethal means in House Bill 2.
- The Montana Veteran Affairs Division and the Department of Public Health and Human Services (DPHHS) signed a memorandum of understanding transferring the funds and responsibility for executing the mission to DPHHS and the Montana Warriors Forward program.
- Lewis and Clark County Public Health were tasked with expanding the Safer Communities Montana ( https://lcsuicideprevention.org/safer-communities-montana-lethal-means /) program statewide during 2026-2027.
- Three tasks were identified:
  1. Establish safe storage sites across Montana and connect them with 211 and 988.
  2. Conduct safe storage training, in accordance with best practices.
  3. Promote safe storage through media and engagement with stakeholders.

A Montana Warriors Forward webpage was created with a resource map.

- Links to partners and stakeholders
- Resources and toolkits for VSOs and peers.
- Interactive map of SMVF resources at: https://jgresearch.maps.arcgis.com/apps/instant/portfolio/index.html?appid=dd01000b674647d2b6bfce6927f41a31





MONTANA DPHHS DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

# *SUICIDE AND THE PRESCRIPTION DRUG REGISTRY*

In the 2023 legislative session, the Montana legislature passed SB 284, an act revising laws related to reporting of drugs taken by or prescribed to individuals whose death were ruled to be a suicide. This bill requires a report on toxicology and controlled substance information in deaths ruled to be a suicide.

The following data was based on the 2025 suicides that occurred in Montana. The suicides were cross-referenced with the Prescription Drug Registry. 87 of the suicides were also identified on the Prescription Drug Registry. 32 controlled substances were identified. The chart below depicts which controlled substances were prescribed to the 87 people who died by suicide. These medications were prescribed within 90 days of the death date. On the next page is a similar graph but with the primary use of the controlled substances.

## SUMMARY OF FINDINGS

Of the 87 suicides identified as also being on the Prescription Drug Registry:

Concerning medications found in the system

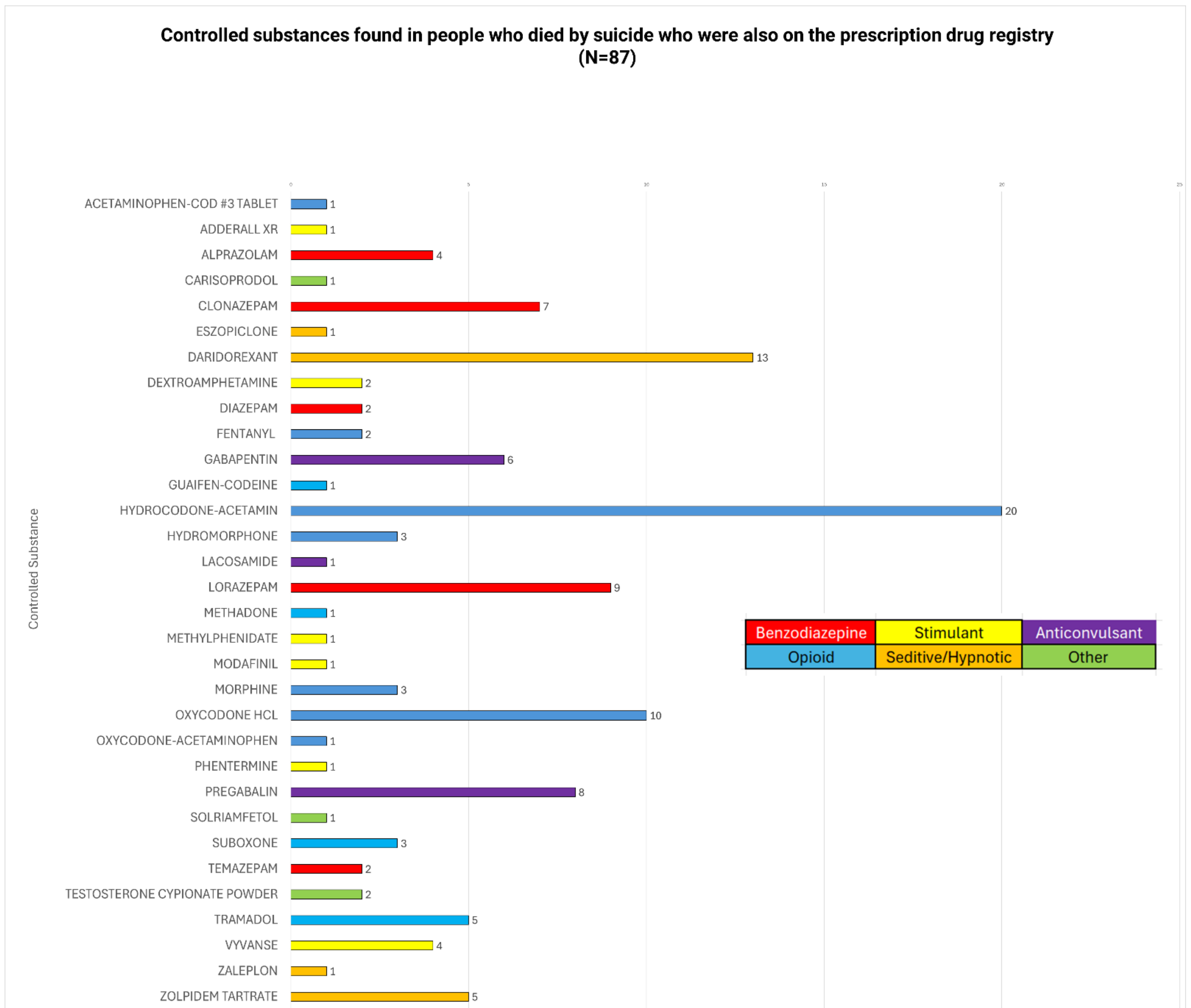
- 57% (50/87) were prescribed an opioid.
  - Of that, 40% (20/50) were Hydrocodone
  - Of that, 20% (10/50) were Oxycodone
- 28% (24/87) were prescribed a benzodiazepine.
  - Of that, 38% (9/24) was Lorazepam
  - Of that, 29% (7/24) was Clonazepam
- 23% (20/87) were prescribed a sedative/hypnotic
  - Of that, 65% (13/20) was Daridorexant
- 17% (15/87) were prescribed an anticonvulsant
  - Of that, 53% (8/15) was Pregabalin
  - Of that, 40% (6/15) was Gabapentin
- 11% (10/87) were prescribed a stimulant.
  - Of that, 40% (4/10) was Vyvanse.

Concerning number of medications found in the system

- 22% (19/88) of the suicides were prescribed 2 or more medications.

Concerning form of payment

- 26% (23/87) used two or more forms of payment to pay for one or multiple medications.
- *23% (20/87) of the prescriptions were paid partially or completely by Medicare/Medicaid*.
- 97% (85/87) of the prescriptions were paid partially or completely by commercial insurance.
  - Only 10% used exclusively commercial insurance.




| Benzodiazepine | Stimulant | Anticonvulsant |
|---|---|---|
| Opioid | Seditive/Hypnotic | Other |

## The following graph includes the primary medical use of each of the controlled substances

| Controlled Substance | # | Primary use of controlled substance |
|---|---|---|
| ACETAMINOPHEN-COD #3 TABLET | 1 | An opioid used to help relieve mild to moderate pain |
| ADDERALL XR | 1 | A stimulant used to treat attention deficit hyperactivity disorder |
| ALPRAZOLAM | 4 | The most prescribed psychotropic medication in the United States. Alprazolam is frequently prescribed to manage panic and anxiety disorders. |
| CARISOPRODOL | 1 | It is used to relax certain muscles in your body and relieve discomfort caused by acute (short-term), painful muscle or bone conditions. |
| CLONAZEPAM | 7 | A benzodiazepine drug used for acute treatment of panic disorder, epilepsy, and nonconvulsive status epilepticus. |
| ESZOPICLONE | 1 | a prescription medicine for adults with insomnia |
| DARIDOREXANT | 13 | a prescription medicine for adults with insomnia |
| DEXTROAMPHETAMINE | 2 | Used to treat attention-deficit hyperactivity disorder (ADHD) and narcolepsy (sleep disorder). |
| DIAZEPAM | 2 | Used to treat anxiety, muscle spasms and seizures. |
| FENTANYL | 2 | A potent synthetic opioid drug approved by the Food and Drug Administration for uses an analgesic (pain relief) and anesthetic. |
| GABAPENTIN | 6 | an anticonvulsant used to treat neuropathic pain and as an adjunctive therapy for partial onset seizures |
| GUAIFENESIN-CODEINE | 1 | Guaifenesin-codeine is classified as an opioid-containing antitussive/expectorant combination used to relieve cough and chest congestion. |
| HYDROCODONE-ACETAMINOPHEN | 20 | This combination medication is used to relieve moderate to severe pain. It contains an opioid pain reliever (hydrocodone) and a non-opioid pain reliever (acetaminophen). |
| HYDROMORPHONE | 3 | This medication belongs to the opioid class of medications and is utilized to effectively manage and treat moderate-to-severe acute pain and severe chronic pain in patients. |
| LACOSAMIDE | 1 | An anticonvulsant used to treat partial-onset and primary generalized tonic-clonic seizures in adults and children |
| LORAZEPAM | 9 | This medication is used to treat anxiety. Lorazepam belongs to a class of drugs known as benzodiazepines |
| METHADONE | 1 | A long-acting synthetic opioid agonist used to treat severe chronic pain and manage opioid use disorder |
| METHYLPHENIDATE | 1 | Methylphenidate is used to treat attention deficit hyperactivity disorder (ADHD). |
| MODAFINIL | 1 | Modafinil is a non-amphetamine central nervous system (CNS) stimulant used in the treatment of conditions that cause excessive daytime sleepiness. |
| MORPHINE | 3 | Morphine is a non-synthetic narcotic with a high potential for abuse and is derived from opium. |
| OXYCODONE HCL | 10 | Oxycodone is an opioid used to relieve severe, acute pain. |
| OXYCODONE-ACETAMINOPHEN | 1 | Oxycodone and acetaminophen combination is used to relieve pain severe enough to require opioid treatment and when other pain medicines did not work well enough or cannot be tolerated. |
| PHENTERMINE | 1 | A stimulant medication used short-term to treat obesity |
| PREGABALIN | 8 | Pregabalin is an anticonvulsant medication that treats nerve pain and seizures. |
| SOLRIAMFETOL | 1 | A prescription medicine for adults that improves wakefulness in patients with excessive daytime sleepiness |
| SUBOXONE | 3 | A prescription medication used to treat opioid addiction by reducing cravings and withdrawal symptoms. |
| TEMAZEPAM | 2 | Temazepam is a benzodiazepine used to treat insomnia (trouble with sleeping). |
| TESTOSTERONE CYPIONATE POWDER | 2 | Testosterone cypionate injection is indicated for replacement therapy in the male in conditions associated with symptoms of deficiency or absence of endogenous testosterone. |
| TRAMADOL | 5 | Tramadol belongs to the group of medicines called opioid analgesics. It acts in the central nervous system (CNS) to relieve pain. |
| VYVANSE | 4 | A stimulant used to treat attention deficit hyperactivity disorder |
| ZALEPLON | 1 | A prescription sedative-hypnotic used for short-term treatment of insomnia |
| ZOLPIDEM TARTRATE | 5 | This is a non-benzodiazepine receptor modulator primarily used in the FDA-approved short-term treatment of insomnia aimed at patients with difficulty falling asleep |