GENERAL AGREEMENT AND CONSENT FOR CHRONIC OPIOID MAINTENANCE THERAPY AND/OR OTHER CONTROLLED SUBSTANCES

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and the medical providers caring for you at [insert practice name] comply with all state and federal regulations concerning the prescribing of controlled substances, and that use of medications are carefully monitored to ensure the safest outcome. This document will also serve to inform you of possible risks associated with chronic opioid therapy. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. Your medical provider's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the clinician/patient relationship and full agreement and understanding of the risks and benefits of using opioids and/or other controlled substances to treat pain.

Clinician/Medical provider means physician, Nurse Practitioner, Physician Assistant, and/or Clinical Pharmacist. You understand and agree that any or all of the clinicians listed herein may be part of your care. In some cases, the Clinical Pharmacist and his/her associates will be directly involved in assessing medication needs and necessary laboratory monitoring directly or indirectly associated with medication therapy. In such cases, you agree to cooperate and collaborate with the clinical pharmacist as you would with your physician. For safety reasons, failure to work with the clinical pharmacist may limit treatment options to non-opioid medication therapies and/or interventional procedures.

1. **You should use one** medical office to prescribe and monitor all opioid medications and adjunctive analgesics.

2. You should use **one** pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by your medical provider.

   Pharmacy: ___________________________ Phone number: ______________________

3. You should inform your clinician of all medications you are taking, including herbal remedies, since opioid medications can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone.

4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment.

5. Prescriptions for pain medicine or any other prescriptions will be ordered only during an office visit or during regular office hours. **No** refills of any medications will be ordered during the evening or on weekends.

6. You must bring back all opioid medications and adjunctive medications prescribed by your physician in the original bottles/packages.

7. You are responsible for keeping your pain medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to your medical provider immediately. If your medications are lost, misplaced or stolen, your medical providers may choose not to replace the medications or to taper and discontinue the medications. Of note, a police report is not considered evidence that medications were stolen; it simply constitutes a **report** of purported theft.

8. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's health. It is also against the law.

9. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other medical providers (which includes emergency rooms, urgent care, dentists, podiatrists, and others), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the clinician/patient relationship.

10. You will communicate fully to your medical provider to the best of your ability at the initial and all follow-up visits, your pain level and functional activity along with any side effects of the medications. This information allows your clinician to adjust your treatment plan accordingly.

11. You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your controlled substance medications when applicable or complete termination of the clinician/patient relationship.

12. The use of alcohol and opioid medications is contraindicated.

13. You agree and understand that your clinician reserves the right to perform random or unannounced urine or blood drug testing. If requested to provide a urine sample, you agree to cooperate. I you decide not to provide a urine sample, you understand that your clinician may change you treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the clinician/patient relationship. The presence of a non-prescribed drug(s) or illicit substance(s) in the urine can be grounds for termination of the clinician/patient relationship. Urine drug testing is not forensic testing, but is done for your benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

14. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing) and death.

15. Physical dependence and/or tolerance can occur with the use of opioid medications.

Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal syndrome can occur. This is a normal physiological response and is not unique to opioids. The withdrawal syndrome from opioid withdrawal could include, but is not exclusively limited to, sweating, nervousness, abdominal cramps, diarrhea, goose bumps**,** and alterations in one's mood.

It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a *realistic* decrease of the patient's pain.

16. If you have a history of alcohol or drug misuse/addiction, you must notify the clinician of such history since the treatment with opioids for pain **may** increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a must.

17. You agree to allow your medical provider or office personnel to contact any health care professional, any emergency room or urgent care facility, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions *if the clinician feels it is necessary*.

18. You agree to a family conference or a conference with a close friend or significant other *if the clinician feels it is necessary*.

The above agreement has been explained to me by [INSERT PRESCRIBER NAME HERE]. I agree to its terms so that [INSERT PRESCRIBER NAME HERE] can provide quality pain management using opioid therapy to decrease my pain and increase my function.

Patient's Signature ______________________________ **Date**__________________________

Witness's Signature ______________________________ **Date**__________________________

Adapted and edited from Howard A. Heit MD, FACP, FASAM
as it appears on https://www.painedu.org/Downloads/AdditionalMaterials/Agreement_for_Opioid_Maintenance_Therapy_for_Non-Cancer_and_Cancer_Pain.pdf